

108TH CONGRESS
2D SESSION

S. 2421

To modernize the health care system through the use of information technology and to reduce costs, improve quality, and provide a new focus on prevention with respect to health care.

IN THE SENATE OF THE UNITED STATES

MAY 13, 2004

Mr. KENNEDY introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

A BILL

To modernize the health care system through the use of information technology and to reduce costs, improve quality, and provide a new focus on prevention with respect to health care.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Health Care Modernization, Cost Reduction, and Quality
6 Improvement Act”.

7 (b) TABLE OF CONTENTS.—The table of contents of
8 this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—INFORMATION TECHNOLOGY

Subtitle A—Improving the Quality of Health Care Through Clinical Informatics

Sec. 101. Improving the quality of health care through clinical informatics.
 Sec. 102. Reimbursement for operation of qualified clinical informatics system.

Subtitle B—Reducing Administrative Costs and Improving Service Through Information Technology

Sec. 111. Requirement for health insurers to implement computerized claims processing systems.
 Sec. 112. Making health care more responsive to the consumer.
 Sec. 113. Regulations.

Subtitle C—Application to Public Health Service Act and Employee Retirement Income Security Act of 1974

Sec. 121. Application to group health plans and group health insurance coverage under the Public Health Service Act.
 Sec. 122. Application to individual health insurance coverage under the Public Health Service Act.
 Sec. 123. Application to group health plans and group health insurance coverage under the Employee Retirement Income Security Act of 1974.

Subtitle D—Miscellaneous Provisions

Sec. 131. Definitions.

TITLE II—PAYING FOR PERFORMANCE

Sec. 201. Health care provider quality standards.

TITLE III—TARGETED QUALITY INITIATIVES

Sec. 301. Improving the quality of care for Americans with diabetes.

“PART R—IMPROVING THE QUALITY OF CARE FOR AMERICANS WITH DIABETES

“Sec. 399A. State diabetes control and prevention programs.
 “Sec. 399A–1. Improving quality of diabetes prevention and care.
 “Sec. 399A–2. National diabetes education and outreach.
 “Sec. 399A–3. Definition.
 Sec. 302. Improving the quality of care for Americans with arthritis.

“PART S—IMPROVING THE QUALITY OF CARE FOR AMERICANS WITH ARTHRITIS

“Sec. 399B. State arthritis control and prevention programs.
 “Sec. 399B–1. Comprehensive arthritis action grants.
 “Sec. 399B–2. National arthritis education and outreach.
 “Sec. 399B–3. Definition.
 Sec. 303. Stroke prevention, treatment, and rehabilitation.

“PART T—STROKE PREVENTION, TREATMENT, AND REHABILITATION
PROGRAMS

- “Sec. 399C. Definitions.
- “Sec. 399C–1. Grants to States for stroke care systems.
- “Sec. 399C–2. Planning grants.
- “Sec. 399C–3. Responsibilities of the secretary.
- Sec. 304. Increasing language access for Americans with limited English proficiency.

“PART C—INCREASING LANGUAGE ACCESS FOR AMERICANS WITH LIMITED
ENGLISH PROFICIENCY

- “Sec. 251. Improving access to services for individuals with limited English proficiency.
- “Sec. 252. National standards for culturally and linguistically appropriate services in healthcare.
- “Sec. 253. Innovations in language access grants.
- “Sec. 254. Standards for language access services.
- “Sec. 255. Report on Federal efforts to provide culturally and linguistically appropriate health care services.
- Sec. 305. Federal reimbursement for culturally and linguistically appropriate services.
- Sec. 306. National Quality Advisory Council.

TITLE IV—PREVENTIVE HEALTH SERVICES

- Sec. 401. Increasing health insurance coverage for prevention.
- Sec. 402. Activities relating to nutrition and physical activity.

“PART U—PREVENTIVE HEALTH CARE

- “Sec. 399D. Encouraging consumption of healthy diets.
- “Sec. 399D–1. Increasing physical activity.
- Sec. 403. Improving immunization.

“PART V—IMPROVING IMMUNIZATION

- “Sec. 399E. Programs to improve the rate of immunization in adults and adolescents.
- “Sec. 399E–1. Curriculum development.
- “Sec. 399E–2. Assuring adequate supply of vaccines for adult and adolescent immunization programs.
- “Sec. 399E–3. Research on immunization programs.
- “Sec. 399E–4. Definition.
- Sec. 404. Improving oral health.

“PART W—IMPROVING ORAL HEALTH

- “Sec. 399F. Public education.
- “Sec. 399F–1. Health care provider education.
- “Sec. 399F–2. Monitoring and evaluating the quality of oral health.
- “Sec. 399F–3. Studies and reports by the Institute of Medicine.
- “Sec. 399F–4. Definition.

1 **TITLE I—INFORMATION**
2 **TECHNOLOGY**
3 **Subtitle A—Improving the Quality**
4 **of Health Care Through Clinical**
5 **Informatics**

6 **SEC. 101. IMPROVING THE QUALITY OF HEALTH CARE**
7 **THROUGH CLINICAL INFORMATICS.**

8 (a) GRANTS TO ENHANCE THE USE OF CLINICAL
9 INFORMATICS.—

10 (1) IN GENERAL.—The Secretary shall award
11 grants or cooperative agreements to eligible entities
12 to assist such entities to acquire, develop, enhance,
13 or implement (including the training of personnel
14 needed for effective implementation) qualified clinical
15 informatics systems that are consistent with the
16 technical standards promulgated by the Secretary
17 under subsection (d).

18 (2) DEFINITION.—In this section, the term
19 “qualified clinical informatics system” means a computerized
20 system (including both hardware and software components
21 of such system) that—

22 (A) maintains and provides immediate access
23 to patients’ medical records in an electronic
24 format;

1 (B) permits a qualified practitioner who
2 wishes to enter an order for a medication, treat-
3 ment, diagnostic procedure, or other interven-
4 tion or service to enter such order via a com-
5 puter that is linked to a database capable of ac-
6 cessing the medical record of the patient who is
7 intended to receive such medication, treatment,
8 diagnostic procedure, or other intervention;

9 (C) incorporates error notification software
10 so that a warning is generated by such system
11 if an order is entered that is likely to lead to
12 a significant adverse outcome for the patient;

13 (D) provides information to a qualified
14 practitioner regarding optimal or recommended
15 alternatives to an order described in subpara-
16 graph (B), provided that such information is
17 not primarily commercial in nature;

18 (E) provides electronic alerts and remind-
19 ers to improve compliance with best practices,
20 promote regular screenings and other preventive
21 practices, and facilitate diagnoses and treat-
22 ments;

23 (F) allows the secure electronic trans-
24 mission of information to other health care pro-
25 viders.

1 (3) GUIDANCE.—The Secretary, acting through
 2 the Director of the Agency for Healthcare Research
 3 and Quality and such other officials as may be ap-
 4 propriate, shall provide technical guidance con-
 5 cerning the elements described in paragraph (2).

6 (4) ENTITIES ELIGIBLE FOR GRANTS OR COOP-
 7 ERATIVE AGREEMENTS.—To be eligible to receive a
 8 grant or cooperative agreement under this sub-
 9 section, an entity shall—

10 (A) be a—

11 (i) Federally qualified health center
 12 (as defined in section 1861(aa)(4) of the
 13 Social Security Act (42 U.S.C.
 14 1395x(aa)(4));

15 (ii) nonprofit hospital, health care
 16 clinic, skilled nursing facility, or other non-
 17 profit health care facility determined by
 18 the Secretary to be eligible and to be in
 19 need of significant financial assistance to
 20 implement a qualified clinical informatics
 21 system; or

22 (iii) group practice as defined in sec-
 23 tion 1877(h)(4) of the Social Security Act
 24 (42 U.S.C. 1395nn(h)(4)), including a
 25 practice that meets the requirements of

1 such section except that such practice has
2 only one physician, and that is in need of
3 significant assistance to implement a quali-
4 fied clinical informatics system;

5 (B) prepare and submit to the Secretary
6 an application at such time, in such manner,
7 and containing such information as the Sec-
8 retary may require, including a description of
9 the qualified clinical informatics system that
10 the entity intends to implement using amounts
11 received under paragraph (1); and

12 (C) submit assurances satisfactory to the
13 Secretary that the entity will conduct the qual-
14 ity improvement activities described in sub-
15 section (e)(1)(A) and subsection (e)(1)(B) if ap-
16 plicable.

17 (5) MATCHING REQUIREMENT.—The Secretary
18 may not make an award under paragraph (1) to an
19 entity described in paragraph (4)(A) unless that en-
20 tity agrees that, with respect to the costs to be in-
21 curred by the entity in carrying out the activities for
22 which the grant or cooperative agreement is being
23 awarded, the entity will make available (directly or
24 through donations from public or private entities)

1 non-Federal contributions toward such costs in an
 2 amount equal to—

3 (A) with respect to an entity described in
 4 paragraph (4)(A)(i), \$1 for each \$10 of Federal
 5 funds provided under the grant or cooperative
 6 agreement; and

7 (B) with respect to an entity described in
 8 paragraph (4)(A)(ii) or (iii), \$1 for each \$5 of
 9 Federal funds provided under the grant or co-
 10 operative agreement.

11 (b) REVOLVING LOAN FUND TO ENHANCE CLINICAL
 12 INFORMATICS.—

13 (1) ESTABLISHMENT OF REVOLVING LOAN
 14 FUND.—The Secretary shall establish a revolving
 15 loan fund—

16 (A) from which the Secretary shall make
 17 loans (subject to the conditions described in
 18 paragraph (3)) to eligible entities to assist such
 19 entities to acquire, develop, enhance, or imple-
 20 ment (including the training of personnel need-
 21 ed for effective implementation) qualified clin-
 22 ical informatics systems that are consistent
 23 with the technical standards promulgated by
 24 the Secretary under subsection (d); and

(B) into which all payments, interest, charges, and other amounts collected from loans made under subparagraph (A) shall, notwithstanding any other provision of law, be deposited.

(2) ELIGIBLE ENTITIES.—To be eligible to receive a loan under this subsection, an entity shall—

(A) be a—

(i) nonprofit hospital, health care clinic, community health center, skilled nursing facility, or other nonprofit health care facility; or

(ii) group practice as defined in section 1877(h)(4) of the Social Security Act (42 U.S.C. 1395nn(h)(4)), including a practice that meets the requirements of such section except that such practice has only one physician;

(B) prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a description of the qualified clinical informatics system that the entity intends to implement using amounts received under paragraph (1); and

1 (C) submit assurances satisfactory to the
2 Secretary that the entity will conduct the qual-
3 ity improvement activities described in sub-
4 section (e)(1)(A) and subsection (e)(1)(B) if ap-
5 plicable.

6 (3) CONDITIONS OF LOANS.—

7 (A) IN GENERAL.—Each loan under this
8 subsection shall be made at a rate of interest
9 that is the greater of—

10 (i) a rate that is 3 percentage points
11 below the rate of interest payable on obli-
12 gations of the Federal Government having
13 terms of maturity of 10 years; or

14 (ii) zero.

15 (B) TERM.—Each loan made under this
16 subsection shall be for a term that does not ex-
17 ceed 7 years.

18 (C) REPAYMENT.—The Secretary may not
19 make a loan to an eligible entity under this sub-
20 section unless the Secretary determines that
21 there is a reasonable expectation that the entity
22 will repay the loan according to the terms of
23 the loan.

24 (D) COLLATERAL.—The Secretary may re-
25 quire an eligible entity receiving a loan under

1 this subsection to provide such collateral as the
2 Secretary determines to be necessary to secure
3 the loan.

4 (E) DEFAULTS AND COLLECTIONS.—Prior
5 to making a loan under this subsection, the
6 Secretary shall establish written procedures and
7 definitions relating to defaults and collections of
8 payments on such loans and shall provide to
9 each applicant for such a loan, at the time of
10 the application, a written copy of such proce-
11 dures and definitions.

12 (F) REGULATIONS.—The Secretary may
13 promulgate such other regulations as may be
14 necessary to carry out the purposes of this sub-
15 section, including regulations involving report-
16 ing and auditing.

17 (4) SEPARATE ACCOUNT AND INVESTMENTS.—
18 The revolving loan fund established under this sub-
19 section shall be maintained by the Secretary as a
20 separate account. Any portion of the revolving loan
21 fund that is not required for expenditure shall be in-
22 vested in obligations of the United States or in obli-
23 gations guaranteed or insured by the United States.

24 (c) LOAN GUARANTEES.—

1 (1) IN GENERAL.—The Secretary shall establish
2 a program under which the Secretary may guarantee
3 up to 90 percent of the principal and interest on
4 loans made by non-Federal lenders to eligible enti-
5 ties for the costs of acquiring qualified clinical
6 informatics systems.

7 (2) ELIGIBLE ENTITIES.—To be eligible to re-
8 ceive a loan guarantee under this subsection, an en-
9 tity shall—

10 (A) be a—

11 (i) nonprofit hospital, health care clin-
12 ic, community health center, skilled nurs-
13 ing facility, or other nonprofit health care
14 facility; or

15 (ii) group practice as defined in sec-
16 tion 1877(h)(4) of the Social Security Act
17 (42 U.S.C. 1395nn(h)(4)), including a
18 practice that meets the requirements of
19 such section except that such practice has
20 only one physician;

21 (B) prepare and submit to the Secretary
22 an application at such time, in such manner,
23 and containing such information as the Sec-
24 retary may require, including a description of
25 the qualified clinical informatics system that

1 the entity intends to implement using amounts
2 received under paragraph (1); and

3 (C) submit assurances satisfactory to the
4 Secretary that the entity will conduct the qual-
5 ity improvement activities described in sub-
6 section (e)(1)(A) and subsection (e)(1)(B) if ap-
7 plicable.

8 (3) USE OF FUNDS.—Loan funds guaranteed
9 under this subsection may be used to acquire quali-
10 fied clinical informatics systems that are consistent
11 with the technical standards promulgated by the
12 Secretary under subsection (d).

13 (4) CONDITIONS OF LOAN.—Guarantees of
14 loans under this subsection shall be subject to such
15 further terms and conditions as the Secretary deter-
16 mines to be necessary to assure that the purposes of
17 this subsection will be achieved.

18 (d) PROMULGATION OF TECHNICAL STANDARDS.—
19 Not later than January 1, 2006, the Secretary shall de-
20 velop or adopt technical standards for qualified clinical
21 informatics systems relating to—

22 (1) interoperability;

23 (2) security;

24 (3) the protection of confidentiality, consistent
25 with the regulations promulgated under section

1 264(c) of the Health Insurance Portability and Ac-
 2 countability Act (42 U.S.C. 1320d–2 note); and

3 (4) such other subjects determined appropriate
 4 by the Secretary.

5 (e) QUALITY IMPROVEMENT ACTIVITIES.—

6 (1) IN GENERAL.—As used in this section, the
 7 term “quality improvement activities” means—

8 (A) the use of a qualified clinical
 9 informatics system to report data on the health
 10 care quality standards developed under section
 11 201 of this Act to a utilization and quality con-
 12 trol peer review organization with a contract
 13 under part B of title XI of the Social Security
 14 Act (42 U.S.C. 1320c et seq.), or to any other
 15 patient safety organization recognized by the
 16 Secretary, and to the Secretary in a manner
 17 consistent with the standards developed under
 18 the regulations promulgated under section
 19 264(c) of the Health Insurance Portability and
 20 Accountability Act (42 U.S.C. 1320d–2 note);
 21 and

22 (B) with respect to a health care provider
 23 that employs more than 50 physicians (as such
 24 term is defined in 1861(r) of the Social Secu-
 25 rity Act (42 U.S.C. 1395x(r)) or that is a hos-

1 pital or other institutional provider, the imple-
2 mentation of a program to—

3 (i) analyze (through a process that
4 may include the receipt of analyses con-
5 ducted by other appropriate entities) data
6 on the quality of health care provided by
7 such provider; and

8 (ii) institute measures, based on the
9 analysis conducted under clause (i), to im-
10 prove the quality of health care provided
11 by such provider.

12 (2) PUBLIC AVAILABILITY OF DATA ON QUAL-
13 ITY IMPROVEMENT.—The Secretary shall analyze
14 and make publicly available the data reported to the
15 Secretary under paragraph (1)(A) in a manner de-
16 termined to be of value to patients and health care
17 practitioners.

18 (f) REQUIREMENTS FOR STANDARDS.—

19 (1) CONSULTATION.—In developing the tech-
20 nical standards under subsection (d), the Secretary
21 shall consult with participants in the Consolidated
22 Health Informatics initiative, or any successor to
23 such initiative, and with public and private entities
24 determined appropriate by the Secretary. In devel-
25 oping the standards under subsection (d), the Sec-

1 retary shall take into consideration applicable rec-
2 ommendations of—

3 (A) the National Committee on Vital and
4 Health Statistics; and

5 (B) the Consolidated Health Informatics
6 initiative or any successor to such initiative.

7 (2) OBJECTIVE.—Any standard developed or
8 adopted under subsection (d) shall be consistent with
9 the objectives of improving—

10 (A) patient safety; and

11 (B) the quality of care provided to pa-
12 tients.

13 (3) CONSISTENCY.—The Secretary shall ensure
14 that, to the maximum extent practicable, the stand-
15 ards adopted or developed under subsection (d) shall
16 be consistent with—

17 (A) any standards otherwise adopted or de-
18 veloped by the Secretary under the Social Secu-
19 rity Act for transactions and data elements to
20 enable the electronic transmission of prescrip-
21 tions; and

22 (B) any standards adopted by the Consoli-
23 dated Health Informatics initiative, or any suc-
24 cessor to such initiative.

1 (4) ADDITIONS AND MODIFICATIONS TO STAND-
2 ARDS.—Not later than January 1, 2007, and annu-
3 ally thereafter, the Secretary shall review the stand-
4 ards developed or adopted under subsection (d), and
5 may modify such standards and measures if deter-
6 mined appropriate. Any addition or modification to
7 such standards shall be completed in a manner
8 which minimizes the disruption and cost of compli-
9 ance.

10 (g) RESPONSIBILITIES OF THE SECRETARY.—

11 (1) RESEARCH ON EFFECTIVENESS.—The Sec-
12 retary shall conduct research on a representative
13 sample of entities receiving awards under sub-
14 sections (a), (b), and (c) to determine the extent to
15 which qualified clinical informatics systems imple-
16 mented by such entities have improved the quality of
17 care provided to patients receiving care from such
18 entities and reduced the costs of providing high
19 quality health care.

20 (2) TECHNICAL ASSISTANCE.—The Secretary
21 shall provide such technical assistance as is feasible
22 to eligible entities in carrying out activities under
23 this section.

1 (3) USE OF TECHNOLOGY SYSTEMS AND ELEC-
2 TRONIC PAYMENT OF CLAIMS.—The Secretary shall,
3 to the extent technically practicable—

4 (A) utilize information technology systems
5 for—

6 (i) processing financial transactions;

7 (ii) providing reimbursement to pro-
8 viders;

9 (iii) adjudicating claims for reim-
10 bursement; and

11 (iv) providing statements of account
12 or explanations of benefits to providers;
13 and

14 (B) require the submission of claims for
15 payment via electronic means.

16 (4) CONSISTENCY WITH STANDARDS.—Begin-
17 ning on January 1, 2006, the Secretary may not
18 purchase information technology systems unless such
19 systems are consistent with the applicable standards
20 developed under subsection (d).

21 (h) AUTHORIZATION OF APPROPRIATIONS.—There
22 are authorized to be appropriated to carry out this section,
23 such sums as may be necessary.

1 **SEC. 102. REIMBURSEMENT FOR OPERATION OF QUALI-**
 2 **FIED CLINICAL INFORMATICS SYSTEM.**

3 (a) INCREASED REIMBURSEMENT FOR OPERATING
 4 CLINICAL INFORMATICS SYSTEM.—

5 (1) IN GENERAL.—The Secretary shall increase,
 6 by the amount specified in paragraph (2), the reim-
 7 bursement provided under any Federal health pro-
 8 gram to any provider that—

9 (A) operates a qualified clinical informatics
 10 system that is consistent with the technical
 11 standards promulgated under section 101(d);
 12 and

13 (B) conducts the quality improvement ac-
 14 tivities described in section 101(e)(1)(A) and
 15 section 101(e)(1)(B) if applicable.

16 (2) AMOUNT OF INCREASED REIMBURSE-
 17 MENT.—The amount of the increase in a reimburse-
 18 ment under paragraph (1) shall be equal to—

19 (A) for fiscal year 2005, 1 percent of the
 20 amount of the reimbursement involved;

21 (B) for fiscal year 2006, 0.8 percent of the
 22 amount of the reimbursement involved;

23 (C) for fiscal year 2007, 0.6 percent of the
 24 amount of the reimbursement involved;

25 (D) for fiscal year 2008, 0.4 percent of the
 26 amount of the reimbursement involved; and

1 (E) for fiscal year 2009, 0.2 percent of the
2 amount of the reimbursement involved.

3 (b) DECREASED REIMBURSEMENT FOR FAILURE TO
4 OPERATE A CLINICAL INFORMATICS SYSTEM.—

5 (1) IN GENERAL.—The Secretary shall de-
6 crease, by the amount specified in paragraph (2),
7 the reimbursement provided under any Federal
8 health program to any provider unless such pro-
9 vider—

10 (A) operates a qualified clinical informatics
11 system that is consistent with the technical
12 standards promulgated under section 101(d);
13 and

14 (B) conducts the quality improvement ac-
15 tivities described in section 101(e)(1)(A) and
16 section 101(e)(1)(B) if applicable.

17 (2) AMOUNT OF DECREASED REIMBURSE-
18 MENT.—The amount of the decrease in a reimburse-
19 ment under paragraph (1) shall be equal to—

20 (A) for fiscal year 2010, 0.2 percent of the
21 amount of the reimbursement involved;

22 (B) for fiscal year 2011, 0.4 percent of the
23 amount of the reimbursement involved;

24 (C) for fiscal year 2012, 0.6 percent of the
25 amount of the reimbursement involved;

1 (D) for fiscal year 2013, 0.8 percent of the
2 amount of the reimbursement involved; and

3 (E) for fiscal year 2014, and each subse-
4 quent fiscal year, 1.0 percent of the amount of
5 the reimbursement involved.

6 (c) LIMITATION.—Subsection (b) shall not apply to
7 any provider that employs less than 50 health care profes-
8 sionals.

9 **Subtitle B—Reducing Administra-**
10 **tive Costs and Improving Serv-**
11 **ice Through Information Tech-**
12 **nology**

13 **SEC. 111. REQUIREMENT FOR HEALTH INSURERS TO IM-**
14 **PLEMENT COMPUTERIZED CLAIMS PROC-**
15 **ESSING SYSTEMS.**

16 (a) IN GENERAL.—Not later than December 31,
17 2008, each group health plan and health insurance issuer
18 offering health insurance coverage shall have in effect an
19 automated, integrated system that allows for efficient and
20 effective adjudication of claims and the detection of fraud
21 and abuse in accordance with this section.

22 (b) ELEMENTS OF ADJUDICATION.—The system de-
23 scribed in subsection (a) shall include determinations con-
24 cerning payments and coverage for items or services under
25 the terms and conditions of the plan or coverage involved,

1 including any cost-sharing amount that the participant,
2 beneficiary, or enrollee is required to pay with respect to
3 such claim.

4 (c) TIMEFRAME.—The plan or issuer shall complete
5 the adjudication of claims under this section immediately
6 after the plan or issuer receives—

7 (1) the claim; and

8 (2) any additional information requested by the
9 plan or issuer that is necessary to make a deter-
10 mination relating to the claim.

11 (d) ACCURACY.—In adjudicating claims under this
12 section the plan or issuer shall ensure that—

13 (1) such claims are adjudicated with an accu-
14 racy of at least 99 percent;

15 (2) the plan or issuer has the ability to accept
16 claims submitted via the Internet; and

17 (3) the plan or issuer has the ability to issue
18 denials where necessary instantaneously via the
19 Internet, and to provide an opportunity for challenge
20 to and resolution of such denials (except in cases of
21 dispute over medical necessity) via the Internet.

22 (e) DETECTION SYSTEM.—Not later than December
23 31, 2008, each group health plan and health insurance
24 issuer offering health insurance coverage shall use the sys-
25 tem described in subsection (a) to detect fraud and abuse

1 in real-time as part of the adjudication of claims under
2 this section.

3 (f) REGULATIONS.—The Secretary shall issue such
4 regulations as may be necessary or appropriate to carry
5 out this section.

6 **SEC. 112. MAKING HEALTH CARE MORE RESPONSIVE TO**
7 **THE CONSUMER.**

8 (a) STATEMENT OF ACCOUNT FOR CONSUMERS.—

9 (1) IN GENERAL.—Not later than December 31,
10 2008, each group health plan and health insurance
11 issuer offering health insurance coverage shall have
12 in effect a computerized system that provides each
13 participant, beneficiary, or enrollee with a statement
14 of account that—

15 (A) includes information, with respect to
16 the participant, beneficiary, or enrollee, on—

17 (i) claims received, claims denied, and
18 the reasons for any denials;

19 (ii) status of coverage; and

20 (iii) deductible information; and

21 (B) is issued quarterly.

22 (2) INTERNET ACCESS.—The plan or issuer
23 may comply with this subsection by making the
24 quarterly statements available on the Internet 24
25 hours a day, 7 days a week, through a secure website.

1 (b) STATEMENT OF ACCOUNT FOR EMPLOYERS AND
 2 PURCHASES.—Not later than December 31, 2008, each
 3 group health plan and health insurance issuer shall have
 4 in effect a computerized system to provide to employers
 5 and other purchasers of health insurance products a state-
 6 ment of account that—

7 (1) includes—

8 (A) current information on coverage sta-
 9 tus; and

10 (B) reports of customer satisfaction that
 11 are updated annually; and

12 (2) is available 24 hours a day, 7 days a week,
 13 through—

14 (A) the Internet through a secure website;

15 or

16 (B) a toll-free telephone number.

17 (c) INTERNET ENROLLMENT.—

18 (1) IN GENERAL.—Not later than December 31,
 19 2008, each group health plan and health insurance
 20 issuer shall have in effect a computerized system to
 21 provide to employers and other purchasers of health
 22 insurance products an option to enroll for coverage
 23 under such health insurance products on the Inter-
 24 net through a secure website.

1 (2) ELIGIBILITY REQUIREMENTS.—The Inter-
 2 net website described in paragraph (1) shall include
 3 information on eligibility requirements for coverage.

4 (d) CONSUMER EXPLANATION OF BENEFITS.—

5 (1) IN GENERAL.—Not later than December 31,
 6 2008, each group health plan and health insurance
 7 issuer shall have in effect a computerized system to
 8 provide, to a participant, beneficiary, or enrollee—

9 (A) an explanation of benefits at the point
 10 of service or not later than 48 hours after the
 11 time that service is provided; and

12 (B) a description of the coverage and cost
 13 of each services provided to the participant,
 14 beneficiary, or enrollee under the plan or cov-
 15 erage.

16 (2) LANGUAGE.—Any explanation of benefits
 17 under this subsection shall be provided in a printed
 18 form and written in a manner calculated to be un-
 19 derstood by the average participant, beneficiary, or
 20 enrollee.

21 (e) REFERRALS AND AUTHORIZATIONS.—

22 (1) IN GENERAL.—Not later than December 31,
 23 2008, each group health plan and health insurance
 24 issuer shall have in effect a computerized system for
 25 making and checking referrals and pre-authoriza-

1 tions where such referrals and pre-authorizations are
 2 required under the plan or coverage.

3 (2) ACCESS.—The system described in para-
 4 graph (1) shall permit access by physicians and by
 5 participants, beneficiaries, and enrollees to informa-
 6 tion on the completion of referrals and pre-author-
 7 izations and whether health care services and prod-
 8 ucts have been authorized, through—

9 (A) the Internet through a secure website;

10 or

11 (B) a toll-free telephone number.

12 (f) MODERNIZING FINANCIAL TRANSACTIONS IN
 13 HEALTH CARE.—Not later than December 31, 2008, each
 14 group health plan and health insurance issuer offering
 15 health insurance coverage shall have in effect a computer-
 16 ized system that—

17 (1) permits health care providers to receive
 18 claim payments through electronic transfer of funds;

19 (2) permits participants, beneficiaries, and en-
 20 rollees to make payments for deductibles or other re-
 21 quired cost sharing through electronic transfer of
 22 funds; and

23 (3) provides automated, integrated audit con-
 24 trols to monitor any duplicate payments or overpay-
 25 ments within the adjudication system.

1 **SEC. 113. REGULATIONS.**

2 The Secretary shall issue such regulations as may be
3 necessary or appropriate to carry out this subtitle.

4 **Subtitle C—Application to Public**
5 **Health Service Act and Em-**
6 **ployee Retirement Income Secu-**
7 **rity Act of 1974**

8 **SEC. 121. APPLICATION TO GROUP HEALTH PLANS AND**
9 **GROUP HEALTH INSURANCE COVERAGE**
10 **UNDER THE PUBLIC HEALTH SERVICE ACT.**

11 (a) IN GENERAL.—Subpart 2 of part A of title
12 XXVII of the Public Health Service Act is amended by
13 adding at the end the following new section:

14 **“SEC. 2707. IMPROVED QUALITY AND REDUCED COSTS.**

15 “Each group health plan shall comply with the re-
16 quirements under title I of the Health Care Moderniza-
17 tion, Cost Reduction, and Quality Improvement Act, and
18 each health insurance issuer shall comply with health care
19 modernization requirements under such title with respect
20 to group health insurance coverage it offers, and such re-
21 quirements shall be deemed to be incorporated into this
22 subsection.”.

23 (b) CONFORMING AMENDMENT.—Section
24 2721(b)(2)(A) of such Act (42 U.S.C. 300gg–21(b)(2)(A))
25 is amended by inserting “(other than section 2707)” after
26 “requirements of such subparts”.

1 **SEC. 122. APPLICATION TO INDIVIDUAL HEALTH INSUR-**
 2 **ANCE COVERAGE UNDER THE PUBLIC**
 3 **HEALTH SERVICE ACT.**

4 Part B of title XXVII of the Public Health Service
 5 Act is amended by inserting after section 2752 the fol-
 6 lowing new section:

7 **“SEC. 2753. IMPROVED QUALITY AND REDUCED COSTS.**

8 “Each health insurance issuer shall comply with re-
 9 quirements under title I of the Health Care Moderniza-
 10 tion, Cost Reduction, and Quality Improvement Act with
 11 respect to individual health insurance coverage it offers,
 12 and such requirements shall be deemed to be incorporated
 13 into this subsection.”.

14 **SEC. 123. APPLICATION TO GROUP HEALTH PLANS AND**
 15 **GROUP HEALTH INSURANCE COVERAGE**
 16 **UNDER THE EMPLOYEE RETIREMENT IN-**
 17 **COME SECURITY ACT OF 1974.**

18 (a) IN GENERAL.—Subpart B of part 7 of subtitle
 19 B of title I of the Employee Retirement Income Security
 20 Act of 1974 is amended by adding at the end the following
 21 new section:

22 **“SEC. 714. IMPROVED QUALITY AND REDUCED COSTS.**

23 “(a) IN GENERAL.—A group health plan (and a
 24 health insurance issuer offering group health insurance
 25 coverage in connection with such a plan) shall comply with
 26 the requirements of title I of the Health Care Moderniza-

tion, Cost Reduction, and Quality Improvement Act (as in effect as of the date of the enactment of such Act), and such requirements shall be deemed to be incorporated into this subsection.

“(b) PLAN SATISFACTION OF CERTAIN REQUIREMENTS.—For purposes of subsection (a), insofar as a group health plan provides benefits in the form of health insurance coverage through a health insurance issuer, the plan shall be treated as meeting the requirements of title I of the Health Care Modernization, Cost Reduction, and Quality Improvement Act with respect to such benefits and not be considered as failing to meet such requirements because of a failure of the issuer to meet such requirements so long as the plan sponsor or its representatives did not cause such failure by the issuer.

“(c) CONFORMING REGULATIONS.—The Secretary shall issue regulations to coordinate the requirements on group health plans and health insurance issuers under this section with the requirements imposed under the other provisions of this title.”.

(b) CONFORMING AMENDMENTS.—

(1) IN GENERAL.—Section 732(a) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185(a)) is amended by striking “section 711” and inserting “sections 711, 714, and 715”.

1 (2) TABLE OF CONTENTS.—The table of con-
 2 tents in section 1 of the Employee Retirement In-
 3 come Security Act of 1974 is amended by inserting
 4 after the item relating to section 713 the following
 5 new item:

“Sec. 714. Improved quality and reduced costs.”.

6 **Subtitle D—Miscellaneous** 7 **Provisions**

8 **SEC. 131. DEFINITIONS.**

9 In this title:

10 (1) CLAIM.—The term “claim” means any re-
 11 quest for coverage (including authorization of cov-
 12 erage), for eligibility, or for payment in whole or in
 13 part, for an item or service under a group health
 14 plan or health insurance coverage.

15 (2) COST SHARING.—The term “cost-sharing”
 16 means any deductibles, coinsurance, copayment
 17 amounts, and liability for balance billing, for which
 18 the participant, beneficiary, or enrollee will be re-
 19 sponsible.

20 (3) ENROLLEE.—The term “enrollee” means,
 21 with respect to health insurance coverage offered by
 22 a health insurance issuer, an individual enrolled with
 23 the issuer to receive such coverage.

24 (4) GROUP HEALTH PLAN.—The term “group
 25 health plan” has the meaning given such term in

1 section 733(a) of the Employee Retirement Income
 2 Security Act of 1974 (29 U.S.C. 1191b(a)).

3 (5) HEALTH CARE PROVIDER.—The term
 4 “health care provider” has the meaning given such
 5 term in section 1855(d)(5) of the Social Security
 6 Act.

7 (6) HEALTH INSURANCE ISSUER.—The term
 8 “health insurance issuer” has the meaning given
 9 such term in section 733(b) of the Employee Retirement
 10 Income Security Act of 1974 (29 U.S.C.
 11 1191b(b)).

12 (7) SECRETARY.—The term “Secretary” means
 13 the Secretary of Health and Human Services.

14 **TITLE II—PAYING FOR** 15 **PERFORMANCE**

16 **SEC. 201. HEALTH CARE PROVIDER QUALITY STANDARDS.**

17 (a) ESTABLISHMENT.—

18 (1) IN GENERAL.—Not later than 2 years after
 19 the date of enactment of this Act, the Secretary of
 20 Health and Human Services (referred to in this sec-
 21 tion as the “Secretary”) shall establish quality
 22 standards for health care providers to be used as an
 23 element of payment or reimbursement for health
 24 care items or services, including providers providing

1 items or services that are paid for by the Federal
2 Government.

3 (2) REQUIREMENTS.—Standards under para-
4 graph (1) shall—

5 (A) be selected and developed in consulta-
6 tion with the National Quality Advisory Coun-
7 cil, other Federal agencies, and the private sec-
8 tor;

9 (B) be established in any area where such
10 a standard is determined by the Secretary to be
11 feasible and appropriate as a basis for payment
12 or reimbursement;

13 (C) be periodically revised and updated;
14 and

15 (D) include standards relating to the proc-
16 ess and outcome of care, as determined feasible
17 and appropriate by the Secretary.

18 (3) APPROPRIATENESS.—In determining feasi-
19 bility and appropriateness under paragraph (2)(B),
20 the Secretary shall take into account the cost of de-
21 termining compliance with the standard relative to
22 the benefit of such standard.

23 (b) PAYMENTS BASED ON COMPLIANCE WITH
24 STANDARDS.—

25 (1) IN GENERAL.—Each health care payor—

1 (A) shall, except as provided in subsection
2 (c), provide enhanced payments to health care
3 providers that achieve or make appropriate
4 progress toward compliance with the applicable
5 quality standards developed under subsection
6 (a); and

7 (B) may provide for reduced payments to
8 health care providers that fail to make appro-
9 priate progress toward, or fail to comply with,
10 such standards.

11 (2) FLEXIBILITY.—In determining whether to
12 provide enhanced or reduced payments under para-
13 graph (1), the health care payor may provide for a
14 time-limited period in which—

15 (A) compliance with the standards are vol-
16 untary for the health care provider involved;
17 and

18 (B) with respect to a health care provider
19 that has failed to comply with the standards,
20 the provider may achieve compliance with the
21 standard in order to gain an enhanced payment
22 or avoid a reduced payment.

23 (3) RULE OF CONSTRUCTION.—Nothing in this
24 subsection shall be construed to—

1 (A) prohibit a health care payor from mak-
 2 ing payments to health care providers for their
 3 performance based on standards in addition to
 4 the standards developed under subsection (a);
 5 and

6 (B) prohibit a health care payor from re-
 7 ducing payments to health care providers who
 8 do not meet the standard, unless specifically
 9 prohibited by the Secretary.

10 (c) AUTHORITY TO LIMIT TO CERTAIN CATEGORIES
 11 OR TYPES OF PROVIDERS.—Each health care payor
 12 may—

13 (1) limit the requirement for enhanced pay-
 14 ments based on compliance with a standard devel-
 15 oped under subsection (a) to certain categories or
 16 types of health care providers;

17 (2) establish alternative standards applicable to
 18 the same condition or course of treatment for dif-
 19 ferent types or categories of health care providers;
 20 and

21 (3) provide for exceptions to the requirements
 22 for enhanced payments based on circumstances in
 23 which payment based on a standard would not serve
 24 the public interest.

1 (d) MANDATORY NEGOTIATION OF PAYMENT FOR
2 VALUE.—

3 (1) IN GENERAL.—If a health care provider de-
4 termines—

5 (A) that, notwithstanding the standards
6 developed under subsection (a), it can provide
7 health care items or services in a manner that
8 will reduce cost and improve the quality of care;
9 and

10 (B) that providing the items or services de-
11 scribed in subparagraph (A) will reduce the
12 amount of reimbursement that would otherwise
13 be available to the provider;

14 the provider may request that the payor involved
15 enter into negotiations to establish an alternative
16 basis of payment.

17 (2) GOOD FAITH NEGOTIATION.—A payor that
18 pays for items or services described in paragraph (1)
19 shall negotiate an alternative basis of payment for
20 health care items or services in good faith. Nothing
21 in the preceding sentence shall be construed to re-
22 quire any payor to agree to a particular method of
23 payment or a level of payment that would result in
24 increased total costs to the payor.

25 (e) SPECIAL STANDARDS FOR CHRONIC CARE.—

1 (1) IN GENERAL.—Standards developed under
 2 subsection (a) for chronic care shall include—

3 (A) coordination of care;

4 (B) patient education in self-management;

5 and

6 (C) systems for tracking and assuring
 7 achievement of process and outcome objectives.

8 (2) CONTRACTS.—In carrying out this sub-
 9 section, health care payors shall enter into contracts
 10 with health care providers that are willing to accept
 11 responsibility for the outcome of care for specific in-
 12 dividuals and shall make standards-based payments
 13 to such providers. Such payments shall cover the
 14 costs of services, such as training in patient self-
 15 management and coordination of care, either directly
 16 or through payments to a contracting provider, pur-
 17 suant to standards specified by the Secretary.

18 (f) HEALTH CARE PAYOR.—In this section, the term
 19 “health care payor” means any entity that pays for, or
 20 reimburses others for payment to, a health care provider
 21 for health care items or services, including a health insur-
 22 ance issuer and the Federal Government.

23 (g) REPORTING REQUIREMENTS.—

24 (1) IN GENERAL.—Each health care provider to
 25 which this section applies shall report to the Sec-

1 retary data on the compliance of the provider with
 2 this section, including data on the quality of health
 3 care provided by such provider and measures to im-
 4 prove the quality of health care provided by such
 5 provider.

6 (2) PUBLIC AVAILABILITY OF DATA.—The Sec-
 7 retary shall analyze and make publicly available the
 8 data reported to the Secretary under paragraph (1)
 9 in a manner determined to be of value to patients
 10 and health care practitioners.

11 **TITLE III—TARGETED QUALITY** 12 **INITIATIVES**

13 **SEC. 301. IMPROVING THE QUALITY OF CARE FOR AMERI-** 14 **CANS WITH DIABETES.**

15 Title III of the Public Health Service Act (42 U.S.C.
 16 241 et seq.) is amended by adding at the end the fol-
 17 lowing:

18 **“PART R—IMPROVING THE QUALITY OF CARE** 19 **FOR AMERICANS WITH DIABETES**

20 **“SEC. 399A. STATE DIABETES CONTROL AND PREVENTION** 21 **PROGRAMS.**

22 “(a) IN GENERAL.—The Secretary, acting through
 23 the Director of the Centers for Disease Control and Pre-
 24 vention and in consultation with appropriate agencies,
 25 shall support comprehensive diabetes control and preven-

1 tion programs by awarding grants to eligible entities to
 2 provide public health surveillance, prevention, and control
 3 activities, and to assure affordable, high-quality diabetes
 4 care.

5 “(b) ELIGIBILITY.—A State or territory is an eligible
 6 entity under this section.

7 “(c) USE OF FUNDS.—Consistent with the com-
 8 prehensive diabetes control and prevention plan submitted
 9 under subsection (d), an eligible entity that receives a
 10 grant under this section may use funds received under
 11 such grant to—

12 “(1) conduct health and community research,
 13 including research on behavioral interventions, to
 14 prevent diabetes (including the development of re-
 15 lated complications) and the onset of type 2 diabetes
 16 in persons with pre-diabetes or persons at high risk
 17 for developing diabetes;

18 “(2) conduct projects, including community-
 19 based programs of diabetes control and prevention,
 20 and similar collaborations with academic institu-
 21 tions, hospitals, community centers, health insurers,
 22 researchers, health professionals, and nonprofit or-
 23 ganizations;

24 “(3) conduct public health surveillance and epi-
 25 demiological activities relating to the prevalence of

1 diabetes and assessing disparities in diabetes control
2 and prevention, including such disparities in under-
3 served populations;

4 “(4) provide public information and education
5 programs; and

6 “(5) provide education and training for health
7 professionals, including allied health professionals.

8 “(d) APPLICATION.—An eligible entity that seeks
9 funding under this section shall submit an application to
10 the Secretary at such time, in such manner, and con-
11 taining such information as the Secretary may require, in-
12 cluding a comprehensive plan for diabetes-related preven-
13 tion and control strategies and activities to be undertaken
14 or supported by the eligible entity, which—

15 “(1) is developed with the advice of stake-
16 holders from the public, private, and nonprofit sec-
17 tors with expertise relating to diabetes control, pre-
18 vention, and treatment;

19 “(2) is intended to reduce the incidence, mor-
20 bidity, and mortality of type 1 and 2 diabetes, with
21 a priority on preventing and controlling diabetes in
22 at-risk populations and reducing disparities in un-
23 derserved populations; and

1 “(3) describes the diabetes-related services and
2 activities to be undertaken or supported by the eligi-
3 ble entity.

4 **“SEC. 399A-1. IMPROVING QUALITY OF DIABETES PREVEN-**
5 **TION AND CARE.**

6 “(a) IN GENERAL.—After completion of activities
7 under subsection (d), the Secretary, acting through the
8 Director of the Centers for Disease Control and Preven-
9 tion, and in collaboration with the Director of the Agency
10 for Healthcare Research and Quality, shall award competi-
11 tive grants to eligible entities to apply the best practices
12 identified by the Secretary under subsection (d) for diabe-
13 tes prevention and control.

14 “(b) ELIGIBILITY.—An entity is eligible for a grant
15 under this section if such entity is—

16 “(1) a State, territory, Indian tribe, tribal orga-
17 nization, public or nonprofit entity; or

18 “(2) a partnership of an entity described in
19 paragraph (1) and an appropriate private sector or-
20 ganization.

21 “(c) PRIORITY.—In awarding grants under this sec-
22 tion, the Secretary shall give priority to eligible entities
23 that propose to carry out programs to reduce disparities
24 in diabetes prevention and control for high-risk or under-
25 served populations.

1 “(d) BEST PRACTICES.—

2 “(1) IN GENERAL.—Not later than 1 year after
3 the date of enactment of this section, the Secretary
4 shall identify evidence-based best practices, evidence-
5 based guidelines and other effective models for dia-
6 betes prevention and control, which may be adopted
7 and applied by eligible entities under this section.

8 “(2) SPECIFIC BEST PRACTICES.—Best prac-
9 tices, as described in paragraph (1), may include—

10 “(A) State or community-based interven-
11 tions, school-based screening, care and preven-
12 tion programs, health systems improvement
13 strategies, and health and environmental poli-
14 cies that promote improved nutrition and phys-
15 ical activity;

16 “(B) case management or disease manage-
17 ment quality improvements programs;

18 “(C) appropriate communication, training,
19 or regional outreach and health promotion ini-
20 tiatives, including Internet-based initiatives; or

21 “(D) models developed or validated by dia-
22 betes research and training centers established
23 under section 431.

24 “(e) APPLICATION.—An eligible entity that seeks
25 funding under this section shall prepare and submit to the

1 Secretary an application at such time, in such manner,
 2 and containing such information as the Secretary deter-
 3 mines to be necessary, including information regarding
 4 how such entity would use funds received under this sec-
 5 tion to supplement activities carried out under such enti-
 6 ty's comprehensive diabetes control and prevention plan
 7 under section 399A.

8 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
 9 are authorized to be appropriated to carry out this section,
 10 \$50,000,000 for fiscal year 2005, and such sums as may
 11 be necessary for each of fiscal years 2006 through 2009.

12 **“SEC. 399A-2. NATIONAL DIABETES EDUCATION AND OUT-**
 13 **REACH.**

14 “(a) PURPOSE.—The Secretary, acting through the
 15 Diabetes Mellitus Interagency Coordinating Committee,
 16 shall coordinate a national diabetes education program to
 17 support, develop, and implement education initiatives and
 18 outreach strategies appropriate for both type 1 and 2 dia-
 19 betes. Such activities may include public awareness cam-
 20 paigns, public service announcements and community
 21 partnership workshops, as well as programs targeted at
 22 businesses and employers, managed care organizations,
 23 and health care providers.

24 “(b) PRIORITY.—The Secretary shall emphasize
 25 translation of new scientific and clinical findings into uti-

1 lizable information for health care providers and patients.
 2 The Secretary shall also give priority to reaching high-risk
 3 or underserved populations.

4 “(c) COLLABORATION.—In carrying out this section,
 5 the Secretary shall consult and collaborate with stake-
 6 holders from the public, private, and nonprofit sectors
 7 with expertise relating to diabetes control, prevention, and
 8 treatment.

9 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
 10 is authorized to be appropriated to carry out this section,
 11 \$15,000,000 for fiscal year 2005 and such sums as may
 12 be necessary for each of fiscal years 2006 through 2009.”.

13 **“SEC. 399A-3. DEFINITION.**

14 “In this part, the term ‘State’ has the meaning given
 15 such term in section 2, and includes Indian tribes.”.

16 **SEC. 302. IMPROVING THE QUALITY OF CARE FOR AMERI-**
 17 **CANS WITH ARTHRITIS.**

18 Title III of the Public Health Service Act (42 U.S.C.
 19 241 et seq.), as amended by section 301, is further amend-
 20 ed by adding at the end the following:

1 **“PART S—IMPROVING THE QUALITY OF CARE**
2 **FOR AMERICANS WITH ARTHRITIS**
3 **“SEC. 399B. STATE ARTHRITIS CONTROL AND PREVENTION**
4 **PROGRAMS.**

5 “(a) IN GENERAL.—The Secretary shall award
6 grants to eligible entities to provide support for com-
7 prehensive arthritis control and prevention programs and
8 to enable such entities to provide public health surveil-
9 lance, prevention, and control activities related to arthritis
10 and other rheumatic diseases.

11 “(b) ELIGIBILITY.—To be eligible to receive a grant
12 under this section, an entity shall be a State or Indian
13 tribe.

14 “(c) APPLICATION.—To be eligible to receive a grant
15 under this section, an entity shall submit to the Secretary
16 an application at such time, in such manner, and con-
17 taining such agreements, assurances, and information as
18 the Secretary may require, including a comprehensive ar-
19 thritis control and prevention plan that—

20 “(1) is developed with the advice of stake-
21 holders from the public, private, and nonprofit sec-
22 tors that have expertise relating to arthritis control,
23 prevention, and treatment that increase the quality
24 of life and decrease the level of disability;

25 “(2) is intended to reduce the morbidity of ar-
26 thritis, with priority on preventing and controlling

1 arthritis in at-risk populations and reducing dispari-
 2 ties in arthritis prevention, diagnosis, management,
 3 and quality of care in underserved populations;

4 “(3) describes the arthritis-related services and
 5 activities to be undertaken or supported by the enti-
 6 ty; and

7 “(4) is developed in a manner that is consistent
 8 with the National Arthritis Action Plan or a subse-
 9 quent strategic plan designated by the Secretary.

10 “(d) USE OF FUNDS.—An eligible entity shall use
 11 amounts received under a grant awarded under subsection
 12 (a) to conduct, in a manner consistent with the com-
 13 prehensive arthritis control and prevention plan submitted
 14 by the entity in the application under subsection (c)—

15 “(1) public health surveillance and epidemiolog-
 16 ical activities relating to the prevalence of arthritis
 17 and assessment of disparities in arthritis prevention,
 18 diagnosis, management, and care;

19 “(2) public information and education pro-
 20 grams; and

21 “(3) education, training, and clinical skills im-
 22 provement activities for health professionals, includ-
 23 ing allied health personnel.

24 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
 25 are authorized to be appropriated to carry out this section

1 such sums as may be necessary for each of fiscal years
 2 2005 through 2009.

3 **“SEC. 399B-1. COMPREHENSIVE ARTHRITIS ACTION**
 4 **GRANTS.**

5 “(a) IN GENERAL.—The Secretary shall award
 6 grants on a competitive basis to eligible entities to enable
 7 such eligible entities to assist in the implementation of a
 8 national strategy for arthritis control and prevention.

9 “(b) ELIGIBILITY.—To be eligible to receive a grant
 10 under this section, an entity shall be a national public or
 11 private nonprofit entity.

12 “(c) APPLICATION.—To be eligible to receive a grant
 13 under this section, an entity shall submit to the Secretary
 14 an application at such time, in such manner, and con-
 15 taining such agreements, assurances, and information as
 16 the Secretary may require, including a description of how
 17 funds received under a grant awarded under this section
 18 will—

19 “(1) supplement or fulfill unmet needs identi-
 20 fied in the comprehensive arthritis control and pre-
 21 vention plan of a State or Indian tribe;

22 “(2) otherwise help achieve the goals of the Na-
 23 tional Arthritis Action Plan or a subsequent stra-
 24 tegic plan designated by the Secretary.

1 “(d) PRIORITY.—In awarding grants under this sec-
2 tion, the Secretary shall give priority to eligible entities
3 submitting applications proposing to carry out programs
4 for controlling and preventing arthritis in at-risk popu-
5 lations or reducing disparities in underserved populations.

6 “(e) USE OF FUNDS.—An eligible entity shall use
7 amounts received under a grant awarded under subsection
8 (a) for 1 or more of the following purposes:

9 “(1) To expand the availability of physical ac-
10 tivity programs designed specifically for people with
11 arthritis.

12 “(2) To provide awareness education to pa-
13 tients, family members, and health care providers, to
14 help such individuals recognize the signs and symp-
15 toms of arthritis, and to address the control and
16 prevention of arthritis.

17 “(3) To decrease long-term consequences of ar-
18 thritis by making information available to individ-
19 uals with regard to the self-management of arthritis.

20 “(4) To provide information on nutrition edu-
21 cation programs with regard to preventing or miti-
22 gating the impact of arthritis.

23 “(f) EVALUATION.—An eligible entity that receives a
24 grant under this section shall submit to the Secretary an
25 evaluation of the operations and activities carried out

1 under such grant that includes an analysis of increased
 2 utilization and benefit of public health programs relevant
 3 to the activities described in the appropriate provisions of
 4 subsection (e).

5 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
 6 are authorized to be appropriated to carry out this section
 7 such sums as may be necessary for each of fiscal years
 8 2005 through 2009.

9 **“SEC. 399B-2. NATIONAL ARTHRITIS EDUCATION AND OUT-**
 10 **REACH.**

11 “(a) IN GENERAL.—The Secretary shall coordinate
 12 a national education and outreach program to support, de-
 13 velop, and implement education initiatives and outreach
 14 strategies appropriate for arthritis and other rheumatic
 15 diseases.

16 “(b) INITIATIVES AND STRATEGIES.—Initiatives and
 17 strategies implemented under the program described in
 18 paragraph (1) may include public awareness campaigns,
 19 public service announcements, and community partnership
 20 workshops, as well as programs targeted at businesses and
 21 employers, managed care organizations, and health care
 22 providers.

23 “(c) PRIORITY.—In carrying out subsection (a), the
 24 Secretary—

7 “(d) COLLABORATION.—In carrying out this section,
8 the Secretary shall consult and collaborate with stake-
9 holders from the public, private, and nonprofit sectors
10 with expertise relating to arthritis control, prevention, and
11 treatment.

16 **“SEC. 399B-3. DEFINITION.**

19 SEC. 303. STROKE PREVENTION, TREATMENT, AND REHA-
20 BILITATION.

•S 2421 IS

1 **“PART T—STROKE PREVENTION, TREATMENT,**
 2 **AND REHABILITATION PROGRAMS**

3 **“SEC. 399C. DEFINITIONS.**

4 In this part:

5 “(1) STROKE CARE SYSTEM.—The term ‘stroke
 6 care system’ means a statewide system to provide
 7 for the diagnosis, prehospital care, hospital definitive
 8 care, and rehabilitation of stroke patients.

9 “(2) STROKE.—The term ‘stroke’ means a
 10 ‘brain attack’ in which blood flow to the brain is in-
 11 terrupted or in which a blood vessel or aneurysm in
 12 the brain breaks or ruptures.

13 **“SEC. 399C-1. GRANTS TO STATES FOR STROKE CARE SYS-**
 14 **TEMS.**

15 “(a) GRANTS.—The Secretary shall award grants to
 16 States for the development and implementation of stroke
 17 care systems that provide high-quality prevention, diag-
 18 nosis, treatment, and rehabilitation.

19 “(b) REQUIRED USES.—

20 “(1) IN GENERAL.—In carrying out activities
 21 described in subsection (a), each State that is
 22 awarded a grant under this section shall—

23 “(A) establish, enhance, or expand a state-
 24 wide stroke care system for the purpose of en-
 25 suring access to high-quality stroke prevention,
 26 diagnosis, treatment, and rehabilitation, except

1 that activities conducted under this subpara-
2 graph shall be consistent with guidelines or rec-
3 ommendations issued by the Secretary under
4 section 399C–3(a)(2) to the extent that such
5 guidelines or recommendations have been
6 issued;

7 “(B) establish, enhance, or expand, as ap-
8 propriate, stroke care centers, except that ac-
9 tivities conducted under this subparagraph shall
10 be consistent with guidelines or recommenda-
11 tions issued by the Secretary under section
12 399C–3(a)(2), to the extent that such guide-
13 lines or recommendations have been issued;

14 “(C) conduct evaluation activities to mon-
15 itor clinical outcomes and procedures and to
16 verify resources, infrastructure, and operations
17 devoted to stroke care;

18 “(D) enhance, develop, and implement a
19 model curriculum for training emergency med-
20 ical services personnel in the identification, as-
21 sessment, stabilization, and prehospital treat-
22 ment of stroke patients, which curriculum may,
23 at the discretion of the State, consist of or be
24 based on the model curriculum developed by the
25 Secretary under section 399C–3(a)(1);

1 “(E) enhance coordination of emergency
2 medical services with respect to stroke care;

3 “(F) establish, enhance, or improve a cen-
4 tral data reporting and analysis system de-
5 scribed in subsection (c);

6 “(G) establish, enhance, or improve a sup-
7 port network described in subsection (d) to pro-
8 vide assistance to facilities with smaller popu-
9 lations of stroke patients or less advanced on-
10 site stroke treatment resources;

11 “(H) consult with organizations and indi-
12 viduals with expertise in stroke prevention, di-
13 agnosis, treatment, and rehabilitation; and

14 “(I) with respect to carrying out subpara-
15 graph (C) through (H), use the best available
16 evidence and consensus recommendations of
17 professional associations.

18 “(2) PERMISSIBLE USES.—In developing and
19 implementing a stroke care system described in
20 paragraph (1), each State that is awarded a grant
21 under this section may—

22 “(A) improve existing State stroke preven-
23 tion programs; and

24 “(B) conduct a stroke education and infor-
25 mation campaign, including by—

1 “(i) making public service announce-
2 ments about the warning signs of stroke
3 and the importance of treating stroke as a
4 medical emergency; and

5 “(ii) providing education regarding
6 ways to prevent stroke and the effective-
7 ness of stroke treatment.

8 “(c) CENTRAL DATA REPORTING AND ANALYSIS
9 SYSTEM.—A central data reporting and analysis system
10 described in this section is a system that collects data from
11 facilities that provide direct care to stroke patients and
12 uses the data—

13 “(1) to identify the number of stroke patients
14 treated in the State;

15 “(2) to monitor patient care in the State for
16 stroke patients at all phases of stroke for the pur-
17 pose of evaluating the diagnosis, treatment, and
18 treatment outcome of such stroke patients;

19 “(3) to identify the total amount of uncompen-
20 sated and under-compensated stroke care expendi-
21 tures for each fiscal year by each stroke care facility
22 in the State;

23 “(4) to identify the number of acute stroke pa-
24 tients who receive advanced drug therapy; and

1 “(5) to identify patients transferred within the
2 statewide stroke care system, including reasons for
3 such transfer.

4 “(d) SUPPORT NETWORK.—A support network de-
5 scribed in this section may include the following:

6 “(1) The use of telehealth technology to connect
7 facilities described in subsection (b)(1)(G) to more
8 advanced stroke care facilities.

9 “(2) The provision of neuroimaging, laboratory,
10 and any other equipment necessary to facilitate the
11 establishment of a telehealth network.

12 “(3) The use of phone consultation, where use-
13 ful.

14 “(4) The use of referral links when a patient
15 needs more advanced care than is available at the
16 facility providing initial care.

17 “(5) The provision of any other assistance de-
18 termined appropriate by the State.

19 “(e) RESTRICTIONS ON USE OF PAYMENTS.—The
20 Secretary may not make payments to a State under this
21 section for a fiscal year unless the State agrees that the
22 payments will not be expended—

23 “(1) to make cash payments to intended recipi-
24 ents of services provided pursuant to this section;

1 “(2) to satisfy any requirement for the expendi-
 2 ture of non-Federal funds as a condition for the re-
 3 ceipt of Federal funds;

4 “(3) to provide financial assistance to any enti-
 5 ty other than a public or nonprofit private entity; or

6 “(4) for construction, alteration, or improve-
 7 ment of any building or facility.

8 “(f) FAILURE TO COMPLY WITH AGREEMENTS.—

9 “(1) REPAYMENT OF PAYMENTS.—

10 “(A) REQUIREMENT.—The Secretary may,
 11 in accordance with paragraph (2), require a
 12 State to repay any payments received by the
 13 State under this section that the Secretary de-
 14 termines were not expended by the State in ac-
 15 cordance with the agreements required to be
 16 made by the State as a condition of the receipt
 17 of the payments.

18 “(B) OFFSET OF AMOUNTS.—If a State
 19 fails to make a repayment required in subpara-
 20 graph (A), the Secretary may offset the amount
 21 of the repayment against any amount due to be
 22 paid to the State under this section.

23 “(2) OPPORTUNITY FOR A HEARING.—Before
 24 requiring repayment of payments under paragraph

1 (1), the Secretary shall provide to the State an op-
2 portunity for a hearing.

3 “(g) APPLICATION REQUIREMENTS.—The Secretary
4 may not award a grant to a State under this section un-
5 less—

6 “(1) the State submits an application con-
7 taining agreements in accordance with this section;

8 “(2) the agreements are made through certifi-
9 cation from the chief executive officer of the State;

10 “(3) with respect to such agreements, the appli-
11 cation provides assurances of compliance satisfactory
12 to the Secretary;

13 “(4) the application contains the plan provi-
14 sions and the information required to be submitted
15 to the Secretary; and

16 “(5) the application otherwise is in such form,
17 is made in such manner, and contains such agree-
18 ments, assurances, and information as the Secretary
19 determines to be necessary to carry out this section.

20 “(h) TECHNICAL ASSISTANCE.—The Secretary shall,
21 without charge to a State receiving payments under this
22 section, provide to the State (or to any public or nonprofit
23 entity designated by the State) technical assistance with
24 respect to the planning, development, and operation of any
25 program carried out pursuant to this section. The Sec-

1 retary may provide such technical assistance directly,
2 through contracts, or through grants.

3 “(i) SUPPLIES AND SERVICES IN LIEU OF GRANT
4 FUNDS.—

5 “(1) IN GENERAL.—Upon the request of a
6 State receiving payments under this section, the Sec-
7 retary may, subject to paragraph (2), provide sup-
8 plies, equipment, and services to the State and may
9 detail to the State any officer or employee of the De-
10 partment of Health and Human Services, for the
11 purpose of assisting the State to achieve the purpose
12 of the payments.

13 “(2) REDUCTION IN PAYMENTS.—With respect
14 to a request described in paragraph (1), the Sec-
15 retary shall reduce the amount of payments to the
16 State under this section by an amount equal to the
17 costs of detailing personnel and the fair market
18 value of any supplies, equipment, or services provided
19 by the Secretary. The Secretary shall, for the pay-
20 ment of expenses incurred in complying with such re-
21 quest, expend the amounts withheld.

22 “(j) LIMITATION ON ADMINISTRATIVE EXPENSES.—
23 The Secretary may not award a grant to a State under
24 this section unless the State agrees to use not more than

1 10 percent of amounts received under the grant for admin-
 2 istrative expenses.

3 “(k) AUTHORIZATION OF APPROPRIATIONS.—There
 4 is authorized to be appropriated to carry out this section,
 5 such sums as may be necessary for each of fiscal years
 6 2005 through 2009.

7 **“SEC. 399C-2. PLANNING GRANTS.**

8 “(a) GRANTS.—The Secretary may award a grant to
 9 a State to assist such State in formulating a plan to de-
 10 velop a stroke care system in accordance with section
 11 399C-1 or in otherwise meeting the requirements of such
 12 section.

13 “(b) SUBMISSION TO SECRETARY.—The chief execu-
 14 tive officer of a State that receives a grant under this sec-
 15 tion shall submit to the Secretary a copy of the plan devel-
 16 oped using the amounts provided under such grant. Such
 17 plan shall be submitted to the Secretary as soon as prac-
 18 ticable after the plan has been developed.

19 “(c) SINGLE GRANT LIMITATION.—A State is not eli-
 20 gible to receive a grant under this section if the State pre-
 21 viously received a grant under this section.

22 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
 23 is authorized to be appropriated to carry out this section,
 24 such sums as may be necessary for each of fiscal years
 25 2005 through 2009.

1 **“SEC. 399C-3. RESPONSIBILITIES OF THE SECRETARY.**

2 “(a) IN GENERAL.—The Secretary shall, with respect
3 to stroke care—

4 “(1) develop a model curriculum for training
5 emergency medical services personnel, including dis-
6 patchers, first responders, emergency medical techni-
7 cians, and paramedics, in the identification, assess-
8 ment, stabilization, and prehospital treatment of
9 stroke patients; and

10 “(2) issue recommendations or guidelines on
11 best practices for the establishment and operation of
12 statewide stroke care systems, including rec-
13 ommendations or guidelines on best practices for the
14 establishment and operation of stroke care centers.

15 “(b) GRANTS, COOPERATIVE AGREEMENTS, AND
16 CONTRACTS.—The Secretary may make grants, and enter
17 into cooperative agreements and contracts, for the purpose
18 of carrying out subsection (a).

19 “(c) RULES OF CONSTRUCTION.—

20 “(1) EXISTING GUIDELINES.—Nothing in sub-
21 section (a)(2) shall be construed to require the Sec-
22 retary to issue new recommendations or guidelines
23 where existing recommendations or guidelines issued
24 or adopted by the Secretary are applicable to the es-
25 tablishment of statewide stroke systems. Where an
26 existing recommendation or guideline is applicable to

1 the establishment of statewide stroke systems, the
 2 Secretary may deem such recommendation or guide-
 3 line to have been issued under subsection (a)(2).

4 “(2) **ADVISORY NATURE OF GUIDELINES.**—Rec-
 5 ommendations or guidelines issued under subsection
 6 (a)(2) shall be considered advisory in nature and
 7 shall not be construed to constitute a standard of
 8 care for the treatment of stroke.”.

9 **SEC. 304. INCREASING LANGUAGE ACCESS FOR AMERICANS**
 10 **WITH LIMITED ENGLISH PROFICIENCY.**

11 Title II of the Public Health Service Act (42 U.S.C.
 12 202 et seq.) is amended by adding at the end thereof the
 13 following:

14 **“PART C—INCREASING LANGUAGE ACCESS FOR**
 15 **AMERICANS WITH LIMITED ENGLISH PRO-**
 16 **FICIENCY**

17 **“SEC. 251. IMPROVING ACCESS TO SERVICES FOR INDIVID-**
 18 **UALS WITH LIMITED ENGLISH PROFICIENCY.**

19 “(a) **PURPOSE.**—As provided in Executive Order
 20 13166, it is the purpose of this section—

21 “(1) to improve access to Federally conducted
 22 and Federally assisted programs and activities for
 23 individuals who are limited in their English pro-
 24 ficiency;

1 “(2) to require each Federal agency to examine
2 the services it provides and develop and implement
3 a system by which limited English proficient individ-
4 uals can enjoy meaningful access to those services
5 consistent with, and without substantially burdening,
6 the fundamental mission of the agency;

7 “(3) to require each Federal agency to ensure
8 that recipients of Federal financial assistance pro-
9 vide meaningful access to their limited English pro-
10 ficient applicants and beneficiaries;

11 “(4) to ensure that recipients of Federal finan-
12 cial assistance take reasonable steps, consistent with
13 the guidelines set forth in the Limited English Pro-
14 ficient Guidance of the Department of Justice (as
15 issued on June 12, 2002), to ensure meaningful ac-
16 cess to their programs and activities by limited
17 English proficient individuals; and

18 “(5) to ensure compliance with title VI of the
19 Civil Rights Act of 1964 and that health care pro-
20 viders and organizations do not discriminate in the
21 provision of services.

22 “(b) FEDERALLY CONDUCTED PROGRAMS AND AC-
23 TIVITIES.—

24 “(1) IN GENERAL.—Not later than 120 days
25 after the date of enactment of this Act, each Federal

1 agency that carries out health care-related activities
 2 shall prepare a plan to improve access to the feder-
 3 ally conducted health care-related programs and ac-
 4 tivities of the agency by limited English proficient
 5 individuals.

6 “(2) PLAN REQUIREMENT.—Each plan under
 7 paragraph (1) shall provide for, at a minimum, the
 8 factors and principles set forth in the Department of
 9 Justice guidance published on June 12, 2002, and
 10 shall include the steps the agency will take to ensure
 11 that limited English proficient individuals have ac-
 12 cess to the agency’s health care-related programs
 13 and activities. Each agency shall send a copy of such
 14 plan to the Department of Justice, which shall serve
 15 as the central repository of the agencies’ plans.

16 “(c) FEDERALLY ASSISTED PROGRAMS AND ACTIVI-
 17 TIES.—

18 “(1) IN GENERAL.—Not later than 120 days
 19 after the date of enactment of this Act, each Federal
 20 agency providing health care-related Federal finan-
 21 cial assistance shall ensure that the guidance for re-
 22 cipients of Federal financial assistance developed by
 23 the agency to ensure compliance with title VI of the
 24 Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.)
 25 is specifically tailored to the recipients of such as-

1 sistance and provides for, at a minimum, the factors
 2 and principles set forth in the Department of Justice
 3 guidance published on June 12, 2002. Each agency
 4 shall send a copy of such guidance to the Depart-
 5 ment of Justice which shall serve as the central re-
 6 pository of the agencies' plans. After approval by the
 7 Department of Justice, each agency shall publish its
 8 guidance document in the Federal Register for pub-
 9 lic comment.

10 “(2) REQUIREMENTS.—The agency-specific
 11 guidance developed under paragraph (1) shall—

12 “(A) detail how the general standards will
 13 be applied to the agency's recipients; and

14 “(B) take into account the types of health
 15 care services provided by the recipients, the in-
 16 dividuals served by the recipients, and other
 17 factors set out in such standards.

18 “(3) EXISTING GUIDANCES.—A Federal agency
 19 that has developed a guidance for purposes of title
 20 VI of the Civil Rights Act of 1964 that the Depart-
 21 ment of Justice determines provides for, at a min-
 22 imum, the factors and principles set forth in the De-
 23 partment of Justice guidance published on June 12,
 24 2002, shall examine such existing guidance, as well
 25 as the programs and activities to which such guid-

1 ance applies, to determine if modification of such
2 guidance is necessary to comply with this subsection.

3 “(4) CONSULTATION.—Each Federal agency
4 shall consult with the Department of Justice in es-
5 tablishing the guidances under this subsection.

6 “(d) CONSULTATIONS.—

7 “(1) IN GENERAL.—In carrying out this sec-
8 tion, each Federal agency that carries out health
9 care-related activities shall ensure that stakeholders,
10 such as limited English proficient individuals and
11 their representative organizations, recipients of Fed-
12 eral assistance, and other appropriate individuals or
13 entities, have an adequate and comparable oppor-
14 tunity to provide input with respect to the actions of
15 the agency.

16 “(2) EVALUATION OF NEEDS.—Each Federal
17 agency described in paragraph (1) shall evaluate the
18 particular needs of the limited English proficient in-
19 dividuals served by the agency, and by a recipient of
20 assistance provided by the agency, and the burdens
21 of compliance with the agency guidance and its re-
22 cipients of the requirements of this section.

1 **“SEC. 252. NATIONAL STANDARDS FOR CULTURALLY AND**
2 **LINGUISTICALLY APPROPRIATE SERVICES IN**
3 **HEALTHCARE.**

4 “Recipients of Federal financial assistance from the
5 Secretary shall, to the extent reasonable and practicable
6 after applying the 4-factor analysis described in title V
7 of the Guidance to Federal Financial Assistance Recipi-
8 ents Regarding Title VI Prohibition Against National Ori-
9 gin Discrimination Affecting Limited-English Proficient
10 Persons (June 12, 2002)—

11 “(1) implement strategies to recruit, retain, and
12 promote individuals at all levels of the organization
13 to maintain a diverse staff and leadership that can
14 provide culturally and linguistically appropriate
15 healthcare to patient populations of the service area
16 of the organization;

17 “(2) ensure that staff at all levels and across all
18 disciplines of the organization receive ongoing edu-
19 cation and training in culturally and linguistically
20 appropriate service delivery;

21 “(3) offer and provide language assistance serv-
22 ices, including bilingual staff and interpreter serv-
23 ices, at no cost to each patient with limited English
24 proficiency at all points of contact, in a timely man-
25 ner during all hours of operation;

1 “(4) notify patients of their right to receive lan-
2 guage assistance services in their primary language;

3 “(5) ensure the competence of language assist-
4 ance provided to limited English proficient patients
5 by interpreters and bilingual staff, and ensure that
6 family and friends are not used to provide interpre-
7 tation services—

8 “(A) except in case of emergency; or

9 “(B) except on request of the patient, who
10 has been informed in his or her preferred lan-
11 guage of the availability of free interpretation
12 services;

13 “(6) make available easily understood patient-
14 related materials including information or notices
15 about termination of benefits and post signage in
16 the languages of the commonly encountered groups
17 or groups represented in the service area of the or-
18 ganization;

19 “(7) develop and implement clear goals, poli-
20 cies, operational plans, and management account-
21 ability and oversight mechanisms to provide cul-
22 turally and linguistically appropriate services;

23 “(8) conduct initial and ongoing organizational
24 self-assessments of culturally and linguistically ap-
25 propriate services-related activities and integrate cul-

1 tural and linguistic competence-related measures
2 into the internal audits, performance improvement
3 programs, patient satisfaction assessments, and out-
4 comes-based evaluations of the organization;

5 “(9) ensure that, consistent with the privacy
6 protections provided for under the regulations pro-
7 mulgated under section 264(c) of the Health Insur-
8 ance Portability and Accountability Act of 1996 (42
9 U.S.C. 1320d–2 note)—

10 “(A) data on the individual patient’s race,
11 ethnicity, and primary language are collected in
12 health records, integrated into the organiza-
13 tion’s management information systems, and
14 periodically updated; and

15 “(B) if the patient is a minor or is inca-
16 pacitated, the primary language of the parent
17 or legal guardian is collected;

18 “(10) maintain a current demographic, cultural,
19 and epidemiological profile of the community as well
20 as a needs assessment to accurately plan for and im-
21 plement services that respond to the cultural and
22 linguistic characteristics of the service area of the
23 organization;

24 “(11) develop participatory, collaborative part-
25 nerships with communities and utilize a variety of

1 formal and informal mechanisms to facilitate com-
 2 munity and patient involvement in designing and im-
 3 plementing culturally and linguistically appropriate
 4 services-related activities;

5 “(12) ensure that conflict and grievance resolu-
 6 tion processes are culturally and linguistically sen-
 7 sitive and capable of identifying, preventing, and re-
 8 solving cross-cultural conflicts or complaints by pa-
 9 tients;

10 “(13) regularly make available to the public in-
 11 formation about their progress and successful inno-
 12 vations in implementing the standards under this
 13 section and provide public notice in their commu-
 14 nities about the availability of this information; and

15 “(14) regularly make available to the head of
 16 each Federal entity from which Federal funds are
 17 received, information about their progress and suc-
 18 cessful innovations in implementing the standards
 19 under this section as required by the head of such
 20 entity.

21 **“SEC. 253. INNOVATIONS IN LANGUAGE ACCESS GRANTS.**

22 “(a) IN GENERAL.—The Secretary, acting through
 23 the Administrator of the Centers for Medicare and Med-
 24 icaid Services, the Administrator of the Health Resources
 25 and Services Administration, and the Director of the Of-

1 fice of Minority Health, shall award grants to eligible enti-
 2 ties to enable such entities to design, implement, and
 3 evaluate innovative, cost-effective programs to improve lin-
 4 guistic access to health care for individuals with limited
 5 English proficiency.

6 “(b) ELIGIBILITY.—To be eligible to receive a grant
 7 under subsection (a) an entity shall—

8 “(1) be a city, county, Indian tribe, State, terri-
 9 tory, community-based nonprofit organization,
 10 health center or community clinic, university, col-
 11 lege, or other entity designated by the Secretary;
 12 and

13 “(2) prepare and submit to the Secretary an
 14 application, at such time, in such manner, and ac-
 15 companied by such additional information as the
 16 Secretary may require.

17 “(c) USE OF FUNDS.—An entity shall use funds re-
 18 ceived under a grant under this section to—

19 “(1) develop, implement, and evaluate models of
 20 providing real-time interpretation services through
 21 in-person interpretation, communications, and com-
 22 puter technology, including the Internet, teleconfer-
 23 encing, or video conferencing;

24 “(2) develop short-term medical interpretation
 25 training courses and incentives for bilingual health

1 care staff who are asked to interpret in the work-
2 place;

3 “(3) develop formal training programs for indi-
4 viduals interested in becoming dedicated health care
5 interpreters;

6 “(4) provide language training courses for
7 health care staff;

8 “(5) provide basic health care-related English
9 language instruction for limited English proficient
10 individuals; or

11 “(6) develop other language assistance services
12 as determined appropriate by the Secretary.

13 “(d) PRIORITY.—In awarding grants under this sec-
14 tion, the Secretary shall give priority to entities that have
15 developed partnerships with organizations or agencies with
16 experience in language access services.

17 “(e) EVALUATION.—An entity that receives a grant
18 under this section shall submit to the Secretary an evalua-
19 tion that describes the activities carried out with funds
20 received under the grant, and how such activities improved
21 access to health care services and the quality of health
22 care for individuals with limited English proficiency. Such
23 evaluation shall be collected and disseminated through the
24 Center for Linguistic and Cultural Competence in
25 Healthcare.

1 “(f) GRANTEE CONVENTION.—The Secretary, acting
 2 through the Director of the Center for Linguistic and Cul-
 3 tural Competence in Healthcare, shall at the end of the
 4 grant cycle convene grantees under this section to share
 5 findings and develop and disseminate model programs and
 6 practices.

7 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
 8 is authorized to be appropriated to carry out this section,
 9 such sums as may be necessary for each of fiscal years
 10 2005 through 2010.

11 **“SEC. 254. STANDARDS FOR LANGUAGE ACCESS SERVICES.**

12 “Not later than 120 days after the date of enactment
 13 of this subtitle, the head of each Federal agency that car-
 14 ries out health care-related activities shall develop and
 15 adopt a guidance on language services for those with lim-
 16 ited English proficiency who attempt to have access to or
 17 participate in such activities that provides at the minimum
 18 the factors and principles set forth in the Department of
 19 Justice guidance published on June 12, 2002.

20 **“SEC. 255. REPORT ON FEDERAL EFFORTS TO PROVIDE**
 21 **CULTURALLY AND LINGUISTICALLY APPRO-**
 22 **PRIATE HEALTH CARE SERVICES.**

23 “Not later than 1 year after the date of enactment
 24 of this subtitle and annually thereafter, the Secretary shall
 25 enter into a contract with the Institute of Medicine for

1 the preparation and publication of a report that describes
 2 federal efforts to ensure that all individuals have meaning-
 3 ful access to culturally and linguistically appropriate
 4 health care services. Such report shall include—

5 “(1) a description and evaluation of the activi-
 6 ties carried out under this part; and

7 “(2) a description of best practices, model pro-
 8 grams, guidelines, and other effective strategies for
 9 providing access to culturally and linguistically ap-
 10 propriate health care services.”.

11 **SEC. 305. FEDERAL REIMBURSEMENT FOR CULTURALLY**
 12 **AND LINGUISTICALLY APPROPRIATE SERV-**
 13 **ICES.**

14 (a) MEDICARE.—Title XVIII of the Social Security
 15 Act (42 U.S.C. 1395 et seq.) is amended by adding at
 16 the end the following:

17 “MEDICARE PAYMENT FOR CULTURALLY AND
 18 LINGUISTICALLY APPROPRIATE SERVICES

19 “SEC. 1898. (a) PAYMENT FOR CULTURALLY AND
 20 LINGUISTICALLY APPROPRIATE SERVICES.—Notwith-
 21 standing any other provision of this title, by not later than
 22 January 1, 2006, the Secretary shall provide several alter-
 23 native additions to the payment amounts for items and
 24 services for which payment may be made under the pay-
 25 ment systems described in subsection (d) for items and
 26 services furnished to a LEP beneficiary (as defined by the

1 Secretary) for the estimated cost of providing quality cul-
2 turally and linguistically appropriate language services
3 (including in-person and telephonic interpreter services
4 and written translation services.

5 “(b) APPLICATION TO SPECIFIC PROVIDERS.—The
6 Secretary shall apply the addition described in subsection
7 (a) to each specific individual or entity paid under a pay-
8 ment system described in subsection (d) that reflects the
9 cost of most efficiently providing such quality services by
10 that individual or entity.

11 “(c) CONSIDERATIONS IN DEVELOPING ALTER-
12 NATIVE AMOUNTS.—In developing the alternative
13 amounts described in subsection (a), the Secretary shall—

14 “(1) consider which types of language access
15 services are most appropriate for the improvement of
16 the quality of care of LEP beneficiaries (as so de-
17 fined), and ensure that interpretation is one of these
18 services;

19 “(2) consider what those services should include
20 and such other factors as the Secretary determines
21 to be appropriate;

22 “(3) consider the cost to a hospital of con-
23 tracting for such services, the cost of providing such
24 services internally, the cost of providing such serv-
25 ices through electronic and telecommunications

1 means, the extra cost of ensuring such services are
2 available with respect to languages not frequently
3 used in the United States, and the extra cost of en-
4 suring such services are available in rural areas;

5 “(4) ensure the adequate adjustment of such
6 additions for annual changes in the cost of providing
7 such services.

8 “(d) PAYMENT SYSTEMS DESCRIBED.—The payment
9 systems described in this subsection are the payments sys-
10 tems under this title, including the following:

11 “(1) INPATIENT HOSPITAL SERVICES.—The
12 prospective payment system for inpatient hospital
13 services under section 1886(d).

14 “(2) HOSPITAL OUTPATIENT DEPARTMENT
15 SERVICES.—The prospective payment system for
16 hospital outpatient department services under sec-
17 tion 1833(t).

18 “(3) PSYCHIATRIC HOSPITALS.—The payment
19 system applicable with respect to psychiatric hos-
20 pitals (as defined in section 1861(f)).

21 “(4) REHABILITATION FACILITIES.—The pro-
22 spective payment system for rehabilitation facilities
23 under section 1886(j).

24 “(5) CHILDREN’S, LONG-TERM CARE, AND CAN-
25 CER HOSPITALS.—The payment systems applicable

1 with respect to hospitals described in clause (iii),
 2 (iv), or (v) of section 1886(d)(1)(B).

3 “(6) SKILLED NURSING FACILITIES.—The pro-
 4 spective payment system for skilled nursing facility
 5 services under section 1888(e).

6 “(7) HOME HEALTH SERVICES.—The prospec-
 7 tive payment system for home health services under
 8 section 1895.

9 “(8) RENAL DIALYSIS FACILITIES.—The pay-
 10 ment system for services provided to end-stage renal
 11 disease patients under section 1881.

12 “(9) PHYSICIANS’ FEE SCHEDULE.—The physi-
 13 cians’ fee schedule under section 1848.

14 “(10) MEDICARE ADVANTAGE PROGRAM.—The
 15 Medicare Advantage program under part C.

16 “(11) VOLUNTARY PRESCRIPTION DRUG BEN-
 17 EFIT PROGRAM.—The voluntary prescription drug
 18 benefit program under part D.”.

19 (b) MEDICAID.—Section 1903(a)(3) of the Social Se-
 20 curity Act (42 U.S.C. 1396b(a)(3)) is amended—

21 (1) in subparagraph (D), by striking “plus” at
 22 the end and inserting “and”; and

23 (2) by adding at the end the following:

24 “(E) 90 percent of the sums expended with
 25 respect to costs incurred during such quarter as

are attributable to the provision of culturally and linguistically appropriate services, including oral interpretation, translations of written materials, and other cultural and linguistic services for individuals with limited English proficiency and disabilities who apply for, or receive, medical assistance under the State plan (including any waiver granted to the State plan); plus”.

(c) SCHIP.—Section 2105(a)(1) of the Social Security Act (42 U.S.C.1397ee(a)), as amended by section 515, is amended—

(1) in the matter preceding subparagraph (A), by inserting “or, in the case of expenditures described in subparagraph (D)(iv), 90 percent” after “enhanced FMAP”; and

(2) in subparagraph (D)—

(A) in clause (iii), by striking “and” at the end;

(B) by redesignating clause (iv) as clause (v); and

(C) by inserting after clause (iii) the following:

“(iv) for expenditures attributable to the provision of culturally and linguistically appropriate services, including oral inter-

1 pretation, translations of written materials,
 2 and other language services for individuals
 3 with limited English proficiency and dis-
 4 abilities who apply for, or receive, child
 5 health assistance under the plan; and”.

6 (d) EFFECTIVE DATE.—The amendments made by
 7 this section take effect on October 1, 2005.

8 **SEC. 306. NATIONAL QUALITY ADVISORY COUNCIL.**

9 (a) ESTABLISHMENT.—There is hereby established
 10 the National Quality Advisory Council (in this section re-
 11 ferred to as the “Council”).

12 (b) MEMBERS.—

13 (1) NUMBER AND APPOINTMENT.—The Council
 14 shall be composed of 15 members to be appointed by
 15 the Comptroller General in accordance with this sub-
 16 section.

17 (2) QUALIFICATION.—

18 (A) IN GENERAL.—The members of the
 19 Council shall include individuals with national
 20 recognition for their expertise in health care
 21 quality, quality measurement systems, con-
 22 sumer reporting, health care management,
 23 health plans and integrated delivery systems,
 24 health care financing, minority (and other vul-
 25 nerable populations) health, and other related

1 fields who provide a mix of different professions
2 and broad geographic and culturally diverse
3 representation.

4 (B) INCLUSION.—The members of the
5 Council shall include physicians and other
6 health professionals, employers, third-party pay-
7 ers, individuals skilled in the conduct and inter-
8 pretation of biomedical health services and
9 health quality research and with expertise in
10 outcomes and effectiveness research and tech-
11 nology assessment, and representatives of con-
12 sumers from diverse backgrounds.

13 (C) MAJORITY NONPROVIDERS.—Individ-
14 uals who are directly involved in the provision,
15 or management of the delivery, of items and
16 services covered under this title shall not con-
17 stitute a majority of the members of the Coun-
18 cil.

19 (D) ETHICAL DISCLOSURE.—The Comp-
20 troller General shall establish a system for the
21 public disclosure, by members of the Council, of
22 financial and other potential conflicts of interest
23 relating to such members.

24 (3) TERMS.—

1 (A) IN GENERAL.—The terms of the mem-
2 bers of the Council shall be for 5 years except
3 that the Comptroller General shall stagger the
4 terms of the members first appointed.

5 (B) VACANCIES.—Any member appointed
6 to fill a vacancy occurring in the Council before
7 the expiration of the term for which the mem-
8 ber's predecessor was appointed shall be ap-
9 pointed only for the remainder of that term. A
10 member may serve after the expiration of that
11 member's term until a successor has been ap-
12 pointed. A vacancy in the membership of the
13 Commission shall be filled in the manner in
14 which the original appointment was made.

15 (4) COMPENSATION.—While carrying out the
16 business of the Council (including travel time), a
17 member of the Council shall be entitled to compensa-
18 tion at the per diem equivalent rate provided for
19 level IV of the Executive Schedule under section
20 5315 of title 5, United States Code, and while so
21 serving away from home and the member's regular
22 place of business, a member may be allowed travel
23 expenses, as authorized by the Chairperson of the
24 Council. Physicians who are members of the Council
25 may be provided a physician comparability allowance

1 by the Council in the same manner as Government
2 physicians may be provided such an allowance by an
3 agency under section 5948 of title 5, United States
4 Code. For purposes of pay (other than pay of mem-
5 bers of the Council) and employment benefits,
6 rights, and privileges, all personnel of the Commis-
7 sion shall be treated as if they were employees of the
8 United States Senate.

9 (5) CHAIRPERSON; VICE CHAIRPERSON.—The
10 Comptroller General shall designate a member of the
11 Council, at the time of the appointment of such
12 member, to serve as the Chairperson of the Council
13 and another member to serve as Vice Chairperson of
14 the Council for that term of appointment, except
15 that in the case of the vacancy of the
16 Chairpersonship or Vice Chairpersonship, the Comp-
17 troller General may designate another member to
18 serve for the remainder of that member's term.

19 (6) MEETINGS.—The Council shall meet at the
20 call of the Chairperson, but in no event less than
21 once every 6 months.

22 (c) DUTIES.—

23 (1) REVIEW OF NATIONAL HEALTH CARE QUAL-
24 ITY.—The Council shall—

1 (A) identify national aims and objectives
2 for health care quality improvement;

3 (B) track the progress of the United
4 States in meeting the aims and objectives identified under subparagraph (A);

5 (C) make recommendations to Congress
6 and the public concerning health care quality
7 policies and programs for improvement; and

8 (D) not later than March 1 of each year
9 (beginning in 2005), submit a report to Congress and the public containing the results of
10 reviews conducted under this subsection and the
11 recommendations of the Council concerning
12 health care quality policies and programs.

13 (2) TOPICS TO BE REVIEWED.—

14 (A) NATIONAL AIMS.—The Council shall
15 review, at the minimum, the following national
16 aims:

17 (i) Reducing avoidable mortality and
18 the underlying causes of illness, injury,
19 and disability.

20 (ii) Expanding research on new treatments and evidence on effectiveness.

21 (iii) Assuring the appropriate use of
22 health care services.

1 (iv) Reducing health care errors.

2 (v) Addressing oversupply and under-
3 supply of health care resources.

4 (vi) Increasing patients' participation
5 in their care and the public's engagement
6 in improving health system performance.

7 (B) NATIONAL OBJECTIVES.—The Council
8 shall develop measurable objectives within each
9 of the national aims described in subparagraph
10 (A) (as well as within any newly identified
11 aims) and such objectives should be revised over
12 time as improvements occur and new concerns
13 arise.

14 (C) QUALITY MEASUREMENT AND REPORT-
15 ING STANDARDS.—The Council shall conduct
16 the following activities:

17 (i) Conduct assessments of the ade-
18 quacy of current quality measures and re-
19 porting standards for the American popu-
20 lation at large as well as for sub-popu-
21 lations defined by age, gender, race, eth-
22 nicity, income, disability, and geography.

23 (ii) Identify processes for the develop-
24 ment of new quality measures and report-
25 ing standards as needed.

1 (iii) Make recommendations to health
 2 care organizations and providers regarding
 3 quality measurement and reporting, both
 4 publicly and privately.

5 (iv) Track the use of recommended
 6 quality measurement and reporting stand-
 7 ards.

8 (v) Make recommendations to Con-
 9 gress concerning health care quality meas-
 10 urement and reporting requirements.

11 (D) DISPARITIES IN HEALTH CARE QUAL-
 12 ITY.—The Council shall include as part of its
 13 overall review under this paragraph, an assess-
 14 ment of health care quality for, at the min-
 15 imum, the following populations:

16 (i) Children and adolescents.

17 (ii) Senior citizens.

18 (iii) Disabled individuals.

19 (iv) Racial, ethnic and limited English
 20 proficient individuals.

21 (v) Women.

22 (vi) Low income individuals.

23 (vii) Geographically diverse popu-
 24 lations.

1 (E) INTERVENTIONS FOR IMPROVEMENT
2 OF HEALTH CARE QUALITY AND HEALTH SYS-
3 TEM PERFORMANCE.—The Council shall con-
4 duct the following activities:

5 (i) Review the evidence base to deter-
6 mine the most effective methods for im-
7 proving patient care and the performance
8 of the health care system, including regula-
9 tion, accreditation, performance based pay-
10 ment, information technologies, manage-
11 ment systems, professional certification,
12 and public reporting of data.

13 (ii) Identify gaps and deficiencies of
14 research to ascertain the most predictable
15 processes and policies associated with im-
16 provements in quality.

17 (iii) Make recommendations to health
18 care organizations and providers regarding
19 quality improvement methods, including
20 appropriate clinical guidelines, both pub-
21 licly and privately.

22 (iv) Make recommendations to Con-
23 gress concerning policies and processes for
24 improvement.

1 (F) CONSUMER BILL OF RIGHTS AND RE-
 2 SPONSIBILITIES.—The Council shall assess the
 3 implementation of this Act with attention to the
 4 following areas:

- 5 (i) Information disclosure.
- 6 (ii) Choice of providers and plans.
- 7 (iii) Access to emergency services.
- 8 (iv) Participation in treatment deci-
 9 sions.
- 10 (v) Respect and nondiscrimination.
- 11 (vi) Confidentiality of health informa-
 12 tion.
- 13 (vii) Complaints and appeals.
- 14 (viii) Consumer responsibilities.

15 (3) COMMENTS ON CERTAIN SECRETARIAL RE-
 16 PORTS.—If the Secretary of Health and Human
 17 Service (referred to in this section as the “Sec-
 18 retary”) submits to Congress (or a committee of
 19 Congress) a report that is required by law, and that
 20 relates to health care quality, including the National
 21 Healthcare Quality Report and the National
 22 Healthcare Disparities Report, the Secretary shall
 23 transmit a copy of the report to the Council. The
 24 Council shall review the report and, not later than
 25 6 months after the date on which such report is

1 transmitted to the Council, shall submit to the ap-
2 propriate committees of Congress written comments
3 on such report. Such comments may include such
4 recommendations as the Council determines appro-
5 priate.

6 (4) AGENDA AND ADDITIONAL REVIEWS.—The
7 Council shall consult periodically with the chairmen
8 and ranking minority members of the appropriate
9 committees of Congress concerning the Council’s
10 agenda and progress towards achieving the agenda.
11 The Council may conduct additional reviews and
12 submit additional reports to the appropriate commit-
13 tees of Congress, from time to time, on such topics
14 relating to the program under this title as may be
15 requested by such chairperson and members and as
16 the Council determines appropriate.

17 (5) AVAILABILITY OF REPORTS.—The Council
18 shall transmit to the Secretary a copy of each report
19 submitted under this subsection and shall make such
20 reports available to the public.

21 (6) APPROPRIATE COMMITTEES OF CON-
22 GRESS.—In this section, the term “appropriate com-
23 mittees of Congress” means the Committee on Ways
24 and Means and the Committee on Energy and Com-
25 merce of the House of Representatives and the Com-

1 mittee on Health, Education, Labor, and Pensions
2 and the Committee on Finance of the Senate.

3 (d) DIRECTOR; STAFF; EXPERTS; CONSULTANTS.—

4 Subject to such review as the Comptroller General deter-
5 mines necessary to ensure the efficient administration of
6 the Council, the Council may—

7 (1) employ and fix the compensation of an Ex-
8 ecutive Director (subject to the approval of the
9 Comptroller General) and such other personnel as
10 may be necessary to carry out its duties (without re-
11 gard to the provision of title 5, United States Code,
12 governing appointments in the competitive service);

13 (2) seek such assistance and support as may be
14 required in the performance of its duties from ap-
15 propriate Federal departments and agencies;

16 (3) enter into contracts or make other arrange-
17 ments, as may be necessary for the conduct of the
18 work of the Council (without regard to section 3709
19 of the Revised Statutes (41 U.S.C. 5));

20 (4) make advance, progress, and other pay-
21 ments which relate to the work of the Council;

22 (5) provide transportation and subsistence for
23 persons serving without compensation; and

1 (6) prescribe such rules and regulations as the
2 Council determines necessary with respects to the in-
3 ternal organization and operation of the Council.

4 (e) POWERS.—

5 (1) OBTAINING OFFICIAL DATA.—The Council
6 may secure directly from any department or agency
7 of the United States information necessary to enable
8 it to carry out this section. Upon request of the
9 Chairperson, the head of such a department or agen-
10 cy shall furnish such information to the Council on
11 an agreed upon schedule.

12 (2) DATA COLLECTION.—In order to carry out
13 its functions, the Council shall—

14 (A) utilize existing information, both pub-
15 lished and unpublished, where possible, collected
16 and assessed either by the staff of the Council
17 or under other arrangements made in accord-
18 ance with this section;

19 (B) carry out, or award grants or con-
20 tracts for, original research and experimen-
21 tation, where existing information is inad-
22 equate; and

23 (C) adopt procedures allowing any inter-
24 ested party to submit information for the Coun-

1 cil's use in making reports and recommenda-
2 tions.

3 (3) ACCESS OF GAO TO INFORMATION.—The
4 Comptroller General shall have unrestricted access
5 to all deliberations, records, and nonproprietary data
6 of the Council, immediately upon request.

7 (4) PERIODIC AUDIT.—The Council shall be
8 subject to periodic audit by the Comptroller General.

9 (f) AUTHORIZATION OF APPROPRIATIONS.—

10 (1) IN GENERAL.—The Council shall submit re-
11 quests for appropriations in the same manner as the
12 Comptroller General submits requests for appropria-
13 tions, but amounts appropriated for the Council
14 shall be separate from amounts appropriated for the
15 Comptroller General.

16 (2) AUTHORIZATION.—There are authorized to
17 be appropriated such sums as may be necessary to
18 carry out this section.

19 **TITLE IV—PREVENTIVE HEALTH** 20 **SERVICES**

21 **SEC. 401. INCREASING HEALTH INSURANCE COVERAGE** 22 **FOR PREVENTION.**

23 (a) APPLICATION TO GROUP HEALTH PLANS AND
24 GROUP HEALTH INSURANCE COVERAGE UNDER THE
25 PUBLIC HEALTH SERVICE ACT.—

1 (1) IN GENERAL.—Subpart 2 of part A of title
 2 XXVII of the Public Health Service Act, as amend-
 3 ed by section 121, is further amended by adding at
 4 the end the following new section:

5 **“SEC. 2708. STANDARDS RELATING TO BENEFITS FOR PRE-**
 6 **VENTIVE SERVICES.**

7 “(a) REQUIREMENTS FOR COVERAGE.—A group
 8 health plan, and a health insurance issuer providing health
 9 insurance coverage in connection with a group health plan,
 10 shall provide coverage for preventive health care items and
 11 services specified by the Secretary under section 401(c)
 12 of the Health Care Modernization, Cost Reduction, and
 13 Quality Improvement Act.

14 “(b) APPLICATION OF CERTAIN PROVISIONS.—The
 15 provisions of subsections (b) (relating to notice), (c) (relat-
 16 ing to prohibitions), (d) (relating to rules of construction),
 17 and (e) (relating to preemption) of section 713 of the Em-
 18 ployee Retirement Income Security Act of 1974 shall
 19 apply to subsection (a) in the same manner as such sub-
 20 sections apply to subsection (a) of such section 713, except
 21 that the date provided for in subsection (b)(3) shall be
 22 January 1, 2005.”.

23 (2) CONFORMING AMENDMENT.—Section
 24 2721(b)(2)(A) of the Public Health Service Act (42
 25 U.S.C. 300gg–21(b)(2)(A)) is amended by inserting

1 “(other than sections 2707 and 2708)” after “re-
2 quirements of such subparts”.

3 (b) APPLICATION TO GROUP HEALTH PLANS AND
4 GROUP HEALTH INSURANCE COVERAGE UNDER THE EM-
5 PLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—

6 (1) IN GENERAL.—Subpart B of part 7 of sub-
7 title B of title I of the Employee Retirement Income
8 Security Act of 1974, as amended by section 123, is
9 further amended by adding at the end the following
10 new section:

11 **“SEC. 715. STANDARDS RELATING TO BENEFITS FOR PRE-
12 VENTIVE SERVICES.**

13 “(a) REQUIREMENTS FOR COVERAGE.—A group
14 health plan, and a health insurance issuer providing health
15 insurance coverage in connection with a group health plan,
16 shall provide coverage for preventive health care items and
17 services specified by the Secretary under section 401(c)
18 of the Health Care Modernization, Cost Reduction, and
19 Quality Improvement Act.

20 “(b) APPLICATION OF CERTAIN PROVISIONS.—The
21 provisions of subsections (b) (relating to notice), (c) (relat-
22 ing to prohibitions), (d) (relating to rules of construction),
23 and (e) (relating to preemption) of section 713 shall apply
24 to subsection (a) in the same manner as such subsections
25 apply to subsection (a) of such section 713, except that

1 the date provided for in subsection (b)(3) shall be January
2 1, 2005.”.

3 (2) CONFORMING AMENDMENTS.—

4 (A) IN GENERAL.—Section 732(a) of the
5 Employee Retirement Income Security Act of
6 1974 (29 U.S.C. 1185(a)) is amended by strik-
7 ing “section 711” and inserting “sections 711,
8 714 and 715”.

9 (B) TABLE OF CONTENTS.—The table of
10 contents in section 1 of the Employee Retirement
11 Income Security Act of 1974 is amended
12 by inserting after the item relating to section
13 714 the following new item:

“Sec. 715. Standards relating to benefits for preventive services.”.

14 (c) PREVENTIVE HEALTH CARE ITEMS AND SERV-
15 ICES.—Not later than January 1, 2005, the Secretary of
16 Health and Human Services, in consultation with the
17 United States Preventive Services Task Force, shall speci-
18 fy those preventive health care items and services to be
19 covered by group health plans and health insurance issuers
20 under the amendments made by this section. In specifying
21 such items and services, the Secretary shall consider the
22 cost and effectiveness of such items and services.

23 (d) EFFECTIVE DATE.—The amendments made by
24 this section shall apply with respect to group health plans

1 and health insurance issuers for plan years beginning on
 2 or after January 1, 2005.

3 **SEC. 402. ACTIVITIES RELATING TO NUTRITION AND PHYS-**
 4 **ICAL ACTIVITY.**

5 Title III of the Public Health Service Act (42 U.S.C.
 6 241 et seq.), as amended by section 303, is further amend-
 7 ed by adding at the end the following:

8 **“PART U—PREVENTIVE HEALTH CARE**

9 **“SEC. 399D. ENCOURAGING HEALTHY DIETS.**

10 “(a) IN GENERAL.—The Secretary, in collaboration
 11 with the Director of the Centers for Disease Control and
 12 Prevention, the Secretary of Education, and the Secretary
 13 of Agriculture, shall establish and implement activities to
 14 encourage health dietary choices (such as fruits and vege-
 15 tables, and foods that are low in fat, sugar, and salt) in
 16 schools, worksites, and communities.

17 “(b) SCHOOLS.—The Secretary, in collaboration with
 18 the Director of the Centers for Disease Control and Pre-
 19 vention, the Secretary of Agriculture, and the Secretary
 20 of Education, shall require elementary and secondary
 21 schools that receive Federal funds to—

22 “(1) ban soft drinks or other foods of minimal
 23 nutritional value from vending machines;

24 “(2) maintain a minimum number of func-
 25 tioning water fountains in school buildings;

1 “(3) prohibit advertisements in schools and on
 2 school grounds for foods of minimal nutritional value
 3 such as fast foods, beverages, and snack foods of
 4 which greater than 50 percent of the calories are de-
 5 rived from fat or simple sugars; and

6 “(4) integrate into school curricula education
 7 about lifelong healthy eating.

8 “(c) WORKSITES.—The Secretary, in collaboration
 9 with the Director of the Centers for Disease Control and
 10 Prevention, the Secretary of Agriculture, and the Sec-
 11 retary of Labor, shall—

12 “(1) ensure the availability of meal selections in
 13 cafeterias, snack stands, and vending machines in
 14 Federal Government buildings that meet the rec-
 15 ommendations of the Secretary for nutritional con-
 16 tent and portion size;

17 “(2) require clear and effective labeling of cal-
 18 ories, fat, trans fat, sugar, sodium, and portion size
 19 for meal selections served in cafeterias and all foods
 20 and beverages sold in vending machines, and at
 21 snack stands in Federal Government buildings, as
 22 determined appropriate by the Secretary;

23 “(3) work with unions, employee associations,
 24 and employer associations to provide technical as-
 25 sistance for the establishment of employee incentive

1 programs to increase participation in worksite health
2 promotion programs that encourage diets in accord-
3 ance with national standards promulgated by the
4 Secretary; and

5 “(4) establish incentive programs to enable em-
6 ployers to partner with local farmers, farmers mar-
7 kets, grocers, and restaurants to increase accessi-
8 bility and availability of fresh fruits and vegetables
9 through worksite cafeterias, snack bars, and vending
10 machines.

11 “(d) COMMUNITIES.—The Secretary, acting through
12 the Director of the Centers for Disease Control and Pre-
13 vention, shall award grants for projects that—

14 “(1) implement campaigns, in communities at
15 risk for poor nutrition, that are designed to promote
16 the intake of foods consistent with established die-
17 tary guidelines through the use of different types of
18 media including television, radio, newspapers, movie
19 theaters, billboards, and mailings;

20 “(2) implement campaigns, in communities at
21 risk for poor nutrition, that promote water as the
22 main daily drink choice through the use of different
23 types of media including television, radio, news-
24 papers, movie theaters, billboards, and mailings;

1 “(3) conduct outreach to commercial food es-
2 tablishments, grocery stores, and other food sup-
3 pliers, to increase the availability and accessibility of
4 healthy foods and beverages;

5 “(4) partner with national programs that pro-
6 vide parents and mentors with the skills to help
7 guide and influence healthy meals and snack selec-
8 tions for children and adolescents; or

9 “(5) partner with national afterschool and sum-
10 mer programs that provide children with the edu-
11 cation and skills needed to make healthy meal and
12 snack selections.

13 “(e) HEALTH PROFESSIONALS.—The Secretary, act-
14 ing through the Administrator of the Health Resources
15 and Services Administration, shall award grants to—

16 “(1) support the development, implementation,
17 and evaluation of curricula to educate and train
18 health professionals about effective nutrition edu-
19 cation and counseling strategies for obese individuals
20 and parents of overweight children, with emphasis
21 on the Dietary Guidelines for Americans or other
22 nationally accepted standards; or

23 “(2) use web-based and related technologies to
24 develop, implement, and evaluate the effectiveness of
25 dietary counseling in health care settings.

1 “(f) EVALUATION.—Not later than 12 months after
 2 the date on which a grant is awarded under this section,
 3 the grantee shall submit to the Director of the Centers
 4 for Disease Control and Prevention a report that describes
 5 the activities carried out with funds received under the
 6 grant and the effectiveness of such activities in improving
 7 the intake of nutritional foods.

8 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
 9 is authorized to be appropriated to carry out this section,
 10 such sums as may be necessary for each of fiscal years
 11 2005 through 2010.

12 **“SEC. 399D–1. INCREASING PHYSICAL ACTIVITY.**

13 “(a) IN GENERAL.—The Secretary, in collaboration
 14 with the Director of the Centers for Disease Control and
 15 Prevention, the Secretary of Education, the Secretary of
 16 Labor, and the Director of the Federal Highway Adminis-
 17 tration, shall establish and implement activities for the
 18 purpose of increasing physical activity in schools, work-
 19 sites, and communities.

20 “(b) SCHOOLS.—The Director of the Centers for Dis-
 21 ease Control and Prevention, in collaboration with the Sec-
 22 retary of Education shall award grants to public elemen-
 23 tary and secondary schools for programs that support—

24 “(1) the provision of daily physical education
 25 for students in kindergarten through grade 12

1 through programs that are consistent with the
2 Guidelines for Physical Activity as reported by the
3 Centers for Disease Control and Prevention and the
4 American College of Sports Medicine and National
5 Physical Education Standards;

6 “(2) the implementation of comprehensive
7 school curricula and school-based physical activity
8 programs that provide education about lifelong phys-
9 ical activity;

10 “(3) training for school personnel that provides
11 the knowledge and skills needed to effectively teach
12 lifelong physical activity; or

13 “(4) evaluations of school physical education
14 programs and facilities at annual intervals to deter-
15 mine the extent to which national guidelines de-
16 scribed in paragraph (1) are met.

17 “(c) WORKSITES.—The Director of the Centers for
18 Disease Control and Prevention, in collaboration with the
19 Secretary, and the Secretary of Labor, shall award grants
20 to eligible entities as determined by the Director, which
21 may include labor organizations, trade associations, trade
22 groups, and businesses for the establishment of projects
23 that include—

24 “(1) the development of activity friendly work-
25 sites (which may include the provision of facilities

1 for physical activity, accessible and attractive stair-
2 wells, walking trails, and supportive management
3 practices) that encourage employee participation in
4 physical activity;

5 “(2) the development of worksite wellness pro-
6 grams that improve physical activity by increasing
7 the knowledge, attitudes, skills, and behaviors of em-
8 ployees; and

9 “(3) the development of employee incentive pro-
10 grams (such as cafeteria discounts, health club
11 memberships, small cash bonuses, and time off) to
12 increase the participation of employees in worksite
13 health promotion programs that increase physical
14 activity.

15 “(d) COMMUNITIES.—The Director of the Centers for
16 Disease Control and Prevention, in collaboration with the
17 Secretary, the Secretary of Transportation, and Secretary
18 of the Interior, shall award grants for the implementation
19 and evaluation of activities that may include—

20 “(1) projects to design pedestrian zones and
21 construct safe walkways and cycling paths;

22 “(2) projects that create greenways and open-
23 space areas linking parks, nature preserves, and cul-
24 tural or historic sites with each other and with popu-

1 lated areas such as residential communities and
2 business locations;

3 “(3) initiatives to increase the use of walking
4 and bicycling as a transportation mode by creating
5 or enhancing informational outreach to parks or
6 community recreation centers; and

7 “(4) community-wide campaigns designed to in-
8 crease physical activity as part of multicomponent
9 efforts that include strategies such as support of self
10 help groups, physical activity counseling, risk factor
11 screening and education, and environmental or pol-
12 icy changes such as the creation of walking trails.

13 “(e) EVALUATION.—Not later than 2 years after the
14 date on which a grant is awarded under this section, the
15 grantee shall submit to the Director of the Centers for
16 Disease Control and Prevention a report that describes the
17 activities carried out with funds receive under the grant
18 and the effectiveness of such activities in increasing phys-
19 ical activity.

20 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
21 is authorized to be appropriated to carry out this section,
22 such sums as may be necessary for each of fiscal years
23 2005 through 2010.”.

1 **SEC. 403. IMPROVING IMMUNIZATION.**

2 Title III of the Public Health Service Act (42 U.S.C.
3 241 et seq.), as amended by section 402, is further amend-
4 ed by adding at the end the following:

5 **“PART V—IMPROVING IMMUNIZATION**

6 **“SEC. 399E. PROGRAMS TO IMPROVE THE RATE OF IMMUNI-**
7 **ZATION IN ADULTS AND ADOLESCENTS.**

8 “(a) DEMONSTRATION PROJECTS.—The Secretary,
9 acting through the Director of the Centers for Disease
10 Control and Prevention, shall award supplemental grants
11 under section 317 to eligible entities for the development,
12 implementation, and evaluation of evidence-based pro-
13 grams that improve the rate of immunization of adults
14 and adolescents.

15 “(b) ELIGIBILITY.—To be eligible to receive a grant
16 under this section an entity shall—

17 “(1) be—

18 “(A) a hospital;

19 “(B) an academic institution;

20 “(C) a nonprofit community based organi-
21 zation;

22 “(D) a health center; or

23 “(E) any other public or private nonprofit
24 entity determined appropriate by the Director
25 of the Centers for Disease Control and Preven-
26 tion;

1 “(2) establish a partnership with a State or
2 local government for purposes of carrying out activi-
3 ties under this section; and

4 “(3) prepare and submit to the Director of the
5 Centers for Disease Control and Prevention an ap-
6 plication at such time, in such manner, and con-
7 taining such information as the Director may re-
8 quire.

9 “(c) USE OF FUNDS.—An entity shall use amounts
10 received under a grant under this section to conduct
11 projects to carry out activities consistent with evidence-
12 based strategies recommended by the Advisory Committee
13 on Immunization Practices and the Task Force on Com-
14 munity Preventive Services, including—

15 “(1) the conduct of public information and edu-
16 cation campaigns that will promote adult and adoles-
17 cent immunizations recommended by the Advisory
18 Committee on Immunization Practices, through the
19 development and dissemination to targeted audiences
20 of appropriate messages about the risks and benefits
21 of immunizations;

22 “(2) the conduct of programs to offer vaccines
23 to underimmunized adult and adolescent populations
24 in settings that have not previously or routinely pro-
25 vided these services, such as family planning, HIV,

1 sexually transmitted disease, and drug treatment
2 centers, emergency departments, pharmacies, home
3 care agencies, senior citizen homes, and correctional
4 facilities;

5 “(3) the conduct of provider-based interventions
6 to promote adult and adolescent vaccinations rec-
7 ommended by the Advisory Committee on Immuniza-
8 tion Practices, which shall include—

9 “(A) the development and implementation
10 of reminder or recall systems that align with
11 State and local immunization information sys-
12 tems and inform health care providers when
13 adult and adolescent patients are due or over-
14 due for specific vaccinations; and

15 “(B) the establishment of standing orders
16 in which non-physician medical personnel de-
17 liver adult and adolescent vaccinations without
18 direct physician involvement at the time of the
19 visit; and

20 “(4) the conduct of programs to identify other
21 interventions and to translate interventions into
22 practice.

23 “(d) DISSEMINATION.—The Director of the Centers
24 for Disease Control and Prevention shall publish and dis-
25 seminate findings made as a result of activities conducted

1 under this section to the public in coordination with the
 2 heads of other appropriate Federal agencies.

3 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
 4 is authorized to be appropriated to carry out this section,
 5 such sums as may be necessary for each of fiscal years
 6 2005 through 2009.

7 **“SEC. 399E-1. CURRICULUM DEVELOPMENT.**

8 “(a) IN GENERAL.—The Director of the Centers for
 9 Disease Control and Prevention shall award competitive
 10 cooperative agreements for the development of innovative
 11 curricula for health care provider training and continuing
 12 education for practicing professionals concerning the as-
 13 sessment, monitoring, improvement, and delivery of immu-
 14 nizations for adults, adolescents, and children.

15 “(b) ELIGIBILITY.—To be eligible to receive a cooper-
 16 ative agreement under this section an entity shall—

17 “(1) be—

18 “(A) an academic institution, such as a
 19 school of medicine, nursing, or pharmacy; or

20 “(B) any other public or private nonprofit
 21 entity determined to be appropriate by the Di-
 22 rector of the Centers for Disease Control and
 23 Prevention; and

24 “(2) prepare and submit to the Director of the
 25 Centers for Disease Control and Prevention an ap-

“(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2005 through 2009.

16 **“SEC. 399E-2. ASSURING ADEQUATE SUPPLY OF VACCINES**
17 **FOR ADULT AND ADOLESCENT IMMUNIZA-**
18 **TION PROGRAMS.**

24 “(b) ELIGIBILITY.—To be eligible to receive a grant
25 under this section, an entity shall—

1 “(1) be an entity determined appropriate by the
2 Director of the Centers for Disease Control and Pre-
3 vention; and

4 “(2) prepare and submit to the Director of the
5 Centers for Disease Control and Prevention an ap-
6 plication at such time, in such manner, and con-
7 taining such information as the Director may re-
8 quire.

9 “(c) USE OF FUNDS.—An entity shall use amounts
10 received under a grant under this section to ensure the
11 availability of vaccines and related supplies to support the
12 implementation of programs to improve the rate of immu-
13 nization in adults and adolescents.

14 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
15 is authorized to be appropriated to carry out this section,
16 such sums as may be necessary for each of fiscal years
17 2005 through 2009.

18 **“SEC. 399E-3. RESEARCH ON IMMUNIZATION PROGRAMS.**

19 “(a) EFFICACY RESEARCH PROJECTS.—The Sec-
20 retary, acting through the Director of the Centers for Dis-
21 ease Control and Prevention, shall award cooperative
22 agreements to eligible entities for the conduct of research
23 and other activities to improve immunization program’s
24 for adults and adolescents.

1 “(b) ELIGIBILITY.—To be eligible to receive a grant
2 under this section an entity shall—

3 “(1) be—

4 “(A) an academic institution;

5 “(B) a nonprofit community based organi-
6 zation;

7 “(C) a State or local health agency; or

8 “(D) any other public or private nonprofit
9 entity determined to be appropriate by the Di-
10 rector of the Centers for Disease Control and
11 Prevention; and

12 “(2) prepare and submit to the Director of the
13 Centers for Disease Control and Prevention an ap-
14 plication at such time, in such manner, and con-
15 taining such information as the Director may re-
16 quire.

17 “(c) USE OF FUNDS.—An entity shall use amounts
18 received under a grant under this section to conduct pro-
19 spective and other research projects on the effect of immu-
20 nization programs in high-risk and underimmunized popu-
21 lations on the rates of immunization, incidence of influ-
22 enza, pneumococcal disease, hepatitis A, hepatitis B, and
23 other vaccine-preventable diseases and related complica-
24 tions.

1 “(d) DISSEMINATION.—The Director of the Centers
 2 for Disease Control and Prevention shall disseminate find-
 3 ings made as a result of activities conducted under this
 4 section to the public in coordination with the heads of
 5 other appropriate Federal agencies.

6 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
 7 is authorized to be appropriated to carry out this section,
 8 such sums as may be necessary for each of fiscal years
 9 2005 through 2009.

10 **“SEC. 399E–4. DEFINITION.**

11 “In this part, the term ‘State’ has the meaning given
 12 such term in section 2, and includes Indian tribes.”.

13 **SEC. 404. IMPROVING ORAL HEALTH.**

14 Title III of the Public Health Service Act (42 U.S.C.
 15 241 et seq.), as amended by section 403, is further amend-
 16 ed by adding at the end the following:

17 **“PART W—IMPROVING ORAL HEALTH**

18 **“SEC. 399F. PUBLIC EDUCATION.**

19 “(a) DEMONSTRATION PROJECTS.—The Secretary,
 20 acting through the Director of the Centers for Disease
 21 Control and Prevention, shall award competitive grants to
 22 eligible entities for the conduct of public education cam-
 23 paigns to raise public awareness concerning oral health.

24 “(b) ELIGIBILITY.—To be eligible to receive a grant
 25 under this section, an entity shall—

1 “(1) be—

2 “(A) a State health agency;

3 “(B) an academic institution;

4 “(C) a nonprofit or community organiza-
5 tion; or

6 “(D) any other public or private nonprofit
7 entity determined to be appropriate by the Di-
8 rector of the Centers for Disease Control and
9 Prevention; and

10 “(2) prepare and submit to the Director of the
11 Centers for Disease Control and Prevention an ap-
12 plication at such time, in such manner, and con-
13 taining such information as the Director may re-
14 quire.

15 “(c) USE OF FUNDS.—An entity shall use amounts
16 received under a grant under this section to partner with
17 a State to—

18 “(1) increase public awareness of oral health
19 issues through public outreach campaigns, particu-
20 larly targeting adult populations including those
21 with intellectual disabilities, and those with chronic
22 diseases such as diabetes; and

23 “(2) develop, implement, and evaluate programs
24 that promote oral health in adults.

1 “(d) DISSEMINATION.—The Director of the Centers
2 for Disease Control and Prevention shall disseminate find-
3 ings made as a result of activities conducted under this
4 section to the public in coordination with the heads of
5 other appropriate Federal agencies.

6 “(e) EVALUATION.—A grantee under this section
7 shall submit to the Director of the Centers for Disease
8 Control and Prevention an evaluation that describes activi-
9 ties carried out with funds received under the grant and
10 the effectiveness of such activities in improving oral health
11 among adults including those with intellectual disabilities
12 or with chronic disease.

13 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
14 is authorized to be appropriated to carry out this section,
15 such sums as may be necessary for each of fiscal years
16 2005 through 2009.

17 **“SEC. 399F-1. HEALTH CARE PROVIDER EDUCATION.**

18 “(a) IN GENERAL.—The Director of the Centers for
19 Disease Control and Prevention shall award competitive
20 grants to entities for the development of innovative cur-
21 ricula for health care providers concerning the delivery of
22 oral care to adults, including adults with intellectual dis-
23 abilities or with chronic disease.

24 “(b) ELIGIBILITY.—To be eligible to receive a grant
25 under this section, an entity shall—

1 “(1) be—

2 “(A) an academic institution;

3 “(B) a health center; or

4 “(C) any other entity determined appro-
5 priate by the Director of the Centers for Dis-
6 ease Control and Prevention; and

7 “(2) prepare and submit to the Director of the
8 Centers for Disease Control and Prevention an ap-
9 plication at such time, in such manner, and con-
10 taining such information as the Director may re-
11 quire.

12 “(c) USE OF FUNDS.—An entity shall use amounts
13 received under a grant under this section to develop, im-
14 plement, and evaluate innovative curricula for health care
15 providers that promotes oral health for adults, including
16 adults with intellectual disabilities or with chronic disease.

17 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
18 is authorized to be appropriated to carry out this section,
19 such sums as may be necessary for each of fiscal years
20 2005 through 2009.

21 **“SEC. 399F-2. MONITORING AND EVALUATING THE QUALITY**
22 **OF ORAL HEALTH.**

23 “(a) DEMONSTRATION PROJECTS.—The Secretary,
24 acting through the Director of the Centers for Disease
25 Control and Prevention, shall award competitive grants to

1 States to expand the ability of States to improve the qual-
2 ity of oral health among adults including adults with intel-
3 lectual disabilities or with chronic disease.

4 “(b) ELIGIBILITY.—To be eligible to receive a grant
5 under this section a State shall prepare and submit to the
6 Director of the Centers for Disease Control and Preven-
7 tion an application at such time, in such manner, and con-
8 taining such information as the Director may require.

9 “(c) CONTRACTING AUTHORITY.—A State receiving
10 a grant under this section may enter into contracts with
11 academic institutions, and other entities determined to be
12 appropriate by the Director, to carry out activities author-
13 ized under this section.

14 “(d) USE OF FUNDS.—A State shall use amounts re-
15 ceived under a grant under this section for activities to
16 improve the oral health of adults, including adults with
17 intellectual disabilities or chronic diseases. Such activities
18 may include—

19 “(1) the collection of public health surveillance
20 information;

21 “(2) the analysis of data to determine the oral
22 health status of adults;

23 “(3) the development and implementation of
24 interventions to improve oral health;

1 “(4) the dissemination of evidence-based best
2 practices; and

3 “(5) the coordination of the sharing of oral
4 health data and evidence based practices between
5 States.

6 “(e) PRIVACY.—A State receiving a grant, or an enti-
7 ty entering into a contract, under this section shall comply
8 with appropriate security and privacy protocols (including
9 protocols required under the regulations promulgated
10 under section 264(c) of the Health Insurance Portability
11 and Accountability Act of 1996 (42 U.S.C. 1320d–2
12 note)), if applicable, with respect to information collected
13 under this section. Nothing in this section shall be con-
14 strued to supersede applicable Federal or State privacy
15 laws.

16 “(f) EVALUATION.—A grantee under this section
17 shall submit to the Director of the Centers for Disease
18 Control and Prevention an evaluation that describes the
19 activities conducted with funds received under the grant
20 and the effectiveness of such activities in improving oral
21 health among adults, including adults with intellectual dis-
22 abilities or with chronic disease.

23 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
24 is authorized to be appropriated to carry out this section

1 and such sums as may be necessary for each of fiscal years
2 2005 through 2009.

3 **“SEC. 399F-3. STUDIES AND REPORTS BY THE INSTITUTE**
4 **OF MEDICINE.**

5 “(a) CONTRACT.—The Secretary shall enter into a
6 contract with the Institute of Medicine to assess existing
7 gaps in, and impediments to, quality oral health, including
8 gaps in data, research and translation, and care provided
9 to adult populations.

10 “(b) AUTHORIZATION OF APPROPRIATIONS.—There
11 is authorized to be appropriated to carry out this section,
12 such sums as may be necessary for each of fiscal years
13 2005 through 2009.

14 **“SEC. 399F-4. DEFINITION.**

15 “In this part, the term ‘State’ has the meaning given
16 such term in section 2, and includes Indian tribes.”.

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